

# **Nursing Facility Medicaid Case Mix Rate Training**



**January 2010**

**Presented by:  
Myers and Stauffer LC  
Per Contract with DHH**

# Training Agenda

## Louisiana Medicaid's Case Mix Reimbursement System for Nursing Facilities

12:30 p.m. – 1:00 p.m.	Registration
1:00 p.m. – 1:10 p.m.	Introductions / Overview Bob Hicks, Manager
1:10 p.m. – 1:25 p.m.	Case Mix Index Development Bob Hicks, Manager
1:25 p.m. – 1:50 p.m.	Cost Report Use In Case Mix Rates Judy Hatfield, Senior Accountant
1:50 p.m. – 2:30 p.m.	Case Mix Rate Calculations Judy Hatfield, Senior Accountant
2:30 p.m. – 2:45 p.m.	BREAK
2:45 p.m. – 3:20 p.m.	Case Mix Rate Calculations (cont.) Dan Brendel, Accountant
3:20 p.m. – 3:35 p.m.	Direct Care / Care-Related Floor Dan Brendel, Accountant
3:35 p.m. – 4:15 p.m.	Special Program Rate Calculations Dan Brendel, Accountant
4:15 p.m. – 4:30 p.m.	Questions and Answers Dan Brendel, Accountant Judy Hatfield, Senior Accountant Bob Hicks, Manager Kevin Londeen, Member
4:30 p.m.	Adjourn

Presented by:  
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# Louisiana Medicaid

## Nursing Facility Case Mix Reimbursement



## Case Mix Reimbursement

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## Case Mix Reimbursement

- Case Mix Index Development
- Cost Report Use In Case Mix Rates
- Case Mix Rate Calculations
- Direct Care / Care-Related Floor
- Leave of Absence Rates
- Wage Enhancement Add-on
- Special Program Rate Calculations
  - Fire Sprinkler
  - Bed Buy Back
  - Private Room Conversions
- Questions & Answers

## Case Mix Index

### Overview

- CMI developed using point-in-time dates
  - January 1, April 1, July 1, October 1
- MDS assessments completed
- Assessments transmitted to the CMS MDS server

# Case Mix Index

## Overview

- Preliminary CMI listing reports are posted to CMS MDS server for providers to download
  - As of January, 2009 the reports are only available electronically
  - See Memo in Appendix I explaining electronic delivery
  - Most current R2b date on or before the point-in-time date will be listed
- Final revisions to MDS transmissions completed by providers
  - Delinquents reviewed and properly discharged, etc..

# Case Mix Index

## Overview

- Final CMI listing reports are posted to the CMS MDS server for providers to download
  - As of January, 2009 the reports are only available electronically
- Final facility-wide CMI calculated and used in the following quarter's case mix rates
- See example of CMI report in Appendix II

## Case Mix Index Sample Dates

Point-In-Time Date	Most current Assessment with an Effective Date, (R2b), on or before	Preliminary Transmission Dates	Preliminary CMI Listing Posted	Final Transmission Dates	Final CMI Listing Posted	Case Mix Index Applies to Reimbursement (Rates)
10/1/09	10/1/09	11/1/09	11/15/09	12/1/09	12/15/09	1/1/10
1/1/10	1/1/10	2/1/10	2/15/10	3/1/10	3/15/10	4/1/10
4/1/10	4/1/10	5/1/10	5/15/10	6/1/10	6/15/10	7/1/10
7/1/10	7/1/10	8/1/10	8/15/10	9/1/10	9/15/10	10/1/10

## Case Mix Index

### Overview

- MDS reviews completed
- Unsupported MDS assessments greater than the threshold will have a new CMI calculated
  - Threshold percentage is now 25%
- Revised CMI will be used to retroactively re-rate rates for the quarter impacted (post-review CMI)

## Questions?



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## Cost Reports

- Historical cost reports are used to set prospective case mix rates
- As published in the October 1, 2009 Louisiana Register, (Appendix X) base resident-day-weighted median costs and prices were rebased effective July 3, 2009 and will be rebased at a minimum every two years thereafter.
- Most recently unqualified audited/desk reviewed cost report as of the April 1<sup>st</sup> prior to the July 1 rate setting is used as the base year cost report for the rebase.
  - The 7/3/2009 rebase included years ending between 1/1/2007 and 12/31/2007
  - Cost report must be 4 months or greater

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## Cost Reports

- Non-filers will receive significant rate penalties and other payment penalties
- Cost reports with qualified or disclaimed opinions may receive significant rate penalties and other penalties at the discretion of the Department

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## Cost Reports

- Louisiana Medicaid Supplemental Cost Report Excel Template
  - Replaced MediMax software for fiscal years ending on/after 6/30/08
  - Available on the Myers and Stauffer web-site:
    - <http://la.mslc.com/Downloads.aspx>
- CMS Form 2540-96 Cost Report

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## Cost Reports

### Medicaid Supplemental Cost Report

- Sample in Appendix III
- Used in rate-setting to identify expenses, statistics, charges, and days that aren't identified separately on the CMS form 2540-96

## Cost Reports

### Medicaid Supplemental Cost Report

- Specific cost detail schedule (Schedule F)
  - Worksheet A line numbers and amounts
    - Raw food
    - Provider fees
    - Property taxes and insurance
    - Contract nursing

## Cost Reports

### Medicaid Supplemental Cost Report

- Specialized care charges (Schedule H-1)
  - Ancillary charges for specialized care services
  - Used to cost out specialized services for possible rebase of specialized care rates

## Cost Reports

### Medicaid Supplemental Cost Report

- Specialized services cost / days (Schedule H-2)
  - Direct cost of ID, TDC, and NRTP services
    - Routine Nursing cost ONLY (cost included in Lines 16 and 18 on Medicare NF cost report)
  - Specialized care costs are excluded from the costs utilized to calculate base resident-day-weighted median costs and prices
  - ID, TDC, and NRTP days

# Cost Reports

## Medicaid Supplemental Cost Report

- Specialized care statistics (Schedule H-3)
  - Overhead allocation statistics for ID, TDC, and NRTP
  - Statistics entered should be a portion of the statistic currently shown on Medicare Worksheet B-1 for the SNF/NF cost centers

# Cost Reports

## Medicaid Supplemental Cost Report

- Nurse aide training schedule (Schedule E-1)
  - Medicaid nurse aide training cost identified and removed from case mix allowable cost
- Reconciliation of Medicare allowable cost and Medicaid allowable cost (Schedule I-1)
  - Administrator / Asst. Administrator salary limits

## Cost Reports

### Medicaid Supplemental Cost Report

- Ancillary/Therapy charge schedule (Schedule G)
  - Break-down of ancillary charges by payer type
  - Should reconcile in total to worksheet C on the Medicare cost report

## Cost Reports

- Each facility's case-mix rate is an all-inclusive rate
  - According to the DHH Standards for Payment for Nursing Facilities, “no fee can be charged a Medicaid resident for specialized rehabilitative services because they are covered facility services.”

## Cost Reports

### CMS Form 2540-96 Cost Report

- Allowable cost, days, and statistics are adjusted to account for the Medicaid supplemental cost report adjustments
- Cost centers on the cost report are grouped into the various rate components (See cross-walk in Appendix IV)
  - Direct Care
  - Care-Related
  - Administrative & Operating
  - Pass-Through (Property Tax & Insurance / Provider Fees)

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## Cost Reports

### CMS Form 2540-96 Cost Report

- Overhead costs are stepped-down so that non-reimbursable and other long-term care cost centers receive a share of the overhead
- Overhead costs are allocated to all applicable cost centers, including other overhead cost centers

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# Cost Reports

## CMS Form 2540-96 Cost Report

- Overhead Example
  - Capital cost is allocated to laundry cost center and then laundry cost is allocated to the nursing facility cost center
- For rate purposes, the original overhead is traced throughout the allocation to determine how much was allocated either directly or indirectly to patient care and non-reimbursable cost centers

# Questions?



## Case Mix Rates

Four cost centers (components):

- Administrative and operating – pricing methodology
- Direct care and care-related – pricing methodology
- Capital – fair rental value methodology
- Pass-through costs (property tax/insurance and provider fees)

## Case Mix Rates

Administrative and operating component

- Cost centers from cost report (refer to crosswalk in Appendix IV)
  - Administrative and general (excluding provider fees)
  - Plant operation and maintenance (excluding any capital cost)
  - Dietary (excluding raw food)
  - Laundry and linen
  - Housekeeping
  - Central services and supply cost
  - Pharmacy cost excluding chargeable drugs
  - Medical Records
  - Employee benefit cost allocated based on salaries

## Case Mix Rates

### Administrative and operating component

- Base year cost inflated by the SNF Market Basket Index Excluding Capital
  - From midpoint of the base year cost report period to the midpoint of the rate year (12/31)
- Inflated cost is divided by total base year resident days to calculate a per diem cost

## Case Mix Rates

### Administrative and operating component

- Inflated per diem cost is arrayed from low to high and resident-day-weighted median cost is determined
- The statewide price is established at 107.5% of the resident-day-weighted median cost
  - Price for the 2010 rate year is \$40.32.

# Case Mix Rates

Administrative and operating median array and price example:

Name	Inflated Per Diem Cost	Resident Days	Cumulative Days (Running Total)
Facility B	\$ 37.39	41,790	41,790
Facility D	\$ 37.40	36,074	77,864
Facility A	\$ 37.42	50,495	128,359
Facility E	\$ 37.50	28,650	157,009
Facility G	<b>\$ 37.51</b>	17,209	<b>174,218</b>
Facility F	\$ 37.52	40,880	215,098
Facility C	\$ 37.52	50,173	265,271
Facility H	\$ 37.54	58,412	323,683
Days Used for Median (0.5 x 323,683)			161,842
<b>Median Selected</b>			<b>\$ 37.51</b>
Multiply by Price % (per rule)			107.50%
<b>Administrative and Operating Statewide Price</b>			<b>\$ 40.32</b>

# Questions?



## Case Mix Rates

### Direct care and care-related components

- Includes a spending floor
- Cost centers from cost report (refer to crosswalk in Appendix IV)
  - Direct Care
    - Nursing salaries/wages and employee benefit allocation
      - RNs
      - LPNs
      - CNAs
    - Contract nursing for direct patient care

## Case Mix Rates

### Direct care and care-related components

- Cost centers from cost report (refer to crosswalk in Appendix IV)
  - Care-related
    - Nursing administration
    - Social service
    - Activities
    - Raw food (removed from dietary)
    - Nursing facility cost center “other” costs (routine supplies/drugs)
    - Employee benefit allocation

## Case Mix Rates

### Direct care and care-related components

- Base year cost inflated by the SNF Market Basket Index Excluding Capital
  - From midpoint of the base year cost report period to the midpoint of the rate year (12/31)

	Direct Care	Care-Related
Base Year Cost (1/1/2007 to 12/31/2007 Cost Report)	\$1,762,705	\$707,709
Inflation Factor (from 6/30/2007 to 12/31/2009)	1.087524	1.087524
<b>Inflated Cost (to Midpoint of the Rate Year)</b>	<b>\$1,916,984</b>	<b>\$769,651</b>

## Case Mix Rates

### Direct care and care-related components

- Inflated cost is divided by total base year resident days to calculate two per diems – direct care and care-related

	Direct Care	Care-Related
Inflated Cost (to Midpoint of the Rate Year)	\$1,916,984	\$769,651
Total Base Year Cost Report Resident Days (Excluding Specialized Care)	43,268	43,268
<b>Per Diem Cost</b>	<b>\$44.30</b>	<b>\$17.79</b>

## Case Mix Rates

Direct care and care-related components

- A cost report period facility-wide CMI is calculated as the simple average of the quarterly facility-wide CMIs that most closely coincide with the facility's cost reporting period used in the rebase

Name	Cost Report Year Begin	Cost Report Year End	CMI Effective Dates	Total CMI
Facility A	1/1/2007	12/31/2007	4/1/2007	1.0820
			7/1/2007	1.0913
			10/1/2007	1.1351
			1/1/2008	1.1823
Average for the Cost Report Period:				<b>1.1227</b>

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## Case Mix Rates

Direct care and care-related components

- Direct care cost per diem is divided by the **cost report period facility-wide CMI** resulting in a "neutralized" direct care cost per diem
- The inflated "neutralized" direct care per diem is added to the inflated care-related per diem

	Direct Care	Care-Related
Per Diem Cost	\$44.30	\$17.79
Cost Report Period Facility-Wide CMI	1.1227	-
Adjusted Cost Per Diem ("Neutralized")	<b>\$39.46</b>	<b>\$17.79</b>

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## Case Mix Rates

### Direct care and care-related components

- The sum of the “neutralized”/inflated direct care per diem and the inflated care-related per diem is arrayed from low to high and the resident-day-weighted median cost is determined
  - 110% of the median is the statewide price
    - Price for the 2010 rate year is \$67.87
  - 94% of the median is the statewide floor

## Case Mix Rates

### Direct care and care-related median, price, & floor:

Name	Inflated "Normalized" Direct Care Per Diem Cost	Inflated Care-Related Per Diem Cost	Total Inflated Per Diem Cost	Resident Days	Cumulative Days (Running Total)
Facility H	\$ 45.00	\$ 16.15	\$ 61.15	31,416	31,416
Facility B	\$ 39.25	\$ 22.38	\$ 61.63	26,583	57,999
Facility E	\$ 39.89	\$ 21.78	\$ 61.67	48,322	106,321
Facility G	\$ 44.25	\$ 17.45	<b>\$ 61.70</b>	38,333	<b>144,654</b>
Facility F	\$ 43.23	\$ 18.55	\$ 61.78	26,735	171,389
Facility D	\$ 41.25	\$ 20.56	\$ 61.81	46,610	217,999
Facility C	\$ 40.15	\$ 21.68	\$ 61.83	30,718	248,717
Facility A	\$ 38.99	\$ 22.88	\$ 61.87	37,314	286,031
Days Used for Median (0.5 x 286,031)					143,016
<b>Median Selected</b>					<b>\$ 61.70</b>
Multiply by Price % (per rule)					110.00%
<b>Direct Care and Care-Related Statewide Price</b>					<b>\$ 67.87</b>
<b>Median Selected</b>					<b>\$ 61.70</b>
Multiply by Floor % at 7/3/2009					94.00%
<b>Direct Care and Care-Related Statewide Floor at 7/3/2009</b>					<b>\$ 58.00</b>

## Case Mix Rates

### Direct care and care-related components

- Facility-specific direct care % = direct care per diem divided by the total of the direct care and care-related per diems (inflated and “neutralized”)
  - Please note that the direct care and care related adjusted cost per diem being used is different from previous slides.

	Direct Care	Care-Related	Total
Adjusted Cost Per Diem ("Neutralized")	\$45.00	\$16.15	\$61.15
Percent to Total	73.59%	26.41%	100.00%

## Case Mix Rates

### Direct care and care-related components

- Statewide price / floor is distributed between direct care and care-related amounts based on the facility’s direct care and care-related percentages

	Direct Care	Care-Related	Total
Percent to Total	73.59%	26.41%	100.00%
Statewide Direct Care / Care-Related Price	\$ 67.87	\$ 67.87	
Distribution of Statewide Price	\$ 49.95	\$ 17.92	\$ 67.87
Statewide Direct Care / Care-Related Floor	\$ 58.00	\$ 58.00	
Distribution of Statewide Floor	\$ 42.68	\$ 15.32	\$ 58.00

## Case Mix Rates

### Direct care and care-related components

- The final facility-specific price / floor = the direct care portion of the statewide price / floor multiplied by the facility's previous quarter's point-in-time CMI and then summed with the care-related portion of the price / floor
  - July 3, 2009 rate uses the April 1, 2009 quarterly CMI

	Direct Care	Care-Related	Total
Distribution of Statewide Price	\$ 49.95	\$ 17.92	\$ 67.87
Multiplied by the Quarterly CMI (4/1/09 Point-In-Time)	1.1858	-	
<b>Facility-Specific Direct Care and Care-Related Price</b>	<b>\$ 59.23</b>	<b>\$ 17.92</b>	<b>\$ 77.15</b>
Distribution of Statewide Floor	\$ 42.68	\$ 15.32	\$ 58.00
Multiplied by the Quarterly CMI (4/1/09 Point-In-Time)	1.1858	-	
<b>Facility-Specific Direct Care and Care-Related Floor</b>	<b>\$ 50.61</b>	<b>\$ 15.32</b>	<b>\$ 65.93</b>

## Case Mix Rates

### Direct care and care-related components

#### Wage Enhancement Add-On

- Rule is in Appendix X (§1321 *Louisiana Register Vol. 35, No. 07 July 20, 2009*).
- Beginning on dates of service on or after February 9, 2007 the facility specific direct care rate was increased by a \$4.70 wage enhancement prior to the case-mix adjustment.
- For dates of service on or after July 3, 2009 the wage add-on is reduced from \$4.70 to \$1.30
- The wage add-on will be fully phased out in the rebase that is on or after July 1, 2010.

# Case Mix Rates

## Direct care and care-related components

- The wage enhancement add-on is a direct care only adjustment, and is subject to CMI adjustment.
- The wage enhancement add-on is also included in calculation of the facility specific direct care and care-related floor.



	Wage Increase	Direct Care	Care-Related	Total
Distribution of Statewide Price	\$ 1.30	\$ 49.95	\$ 17.92	\$ 69.17
Multiplied by the Quarterly CMI (4/1/09 Point-In-Time)	1.1858	1.1858	-	
<b>Facility-Specific Direct Care and Care-Related Price</b>	<b>\$ 1.54</b>	<b>\$ 59.23</b>	<b>\$ 17.92</b>	<b>\$ 78.69</b>
Distribution of Statewide Floor	\$ 1.22	\$ 42.68	\$ 15.32	\$ 59.22
Multiplied by the Quarterly CMI (4/1/09 Point-In-Time)	1.1858	1.1858	-	
<b>Facility-Specific Direct Care and Care-Related Floor</b>	<b>\$ 1.45</b>	<b>\$ 50.61</b>	<b>\$ 15.32</b>	<b>\$ 67.38</b>

# Questions?



## Case Mix Rates

Capital component - fair rental value (FRV)

- No cost data from the cost report is used
- A fair rental value rate is paid in lieu of allowable depreciation, capital related interest, rent/lease, and amortization expenses
- Fair rental value is based on the age and size of the facility

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## Case Mix Rates

Capital component - fair rental value (FRV)

- FRV system elements
  - Facility value – updated annually at July 1
    - \$149.44 per square foot (7/1/09)
    - \$14.96 per square foot for land (7/1/09)
    - \$6,132 per licensed bed for moveable equipment (7/1/09)

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## Case Mix Rates

### Capital component - fair rental value (FRV)

- FRV system elements
  - Facility value – updated annually at July 1
    - Trended annually by the change in per diem unit cost listed in the  $\frac{3}{4}$  column of the R.S. Means Construction Cost Index adjusted for the total city cost index for New Orleans
      - Two-year moving average
    - Minimum of 300 square feet per licensed bed
    - Maximum of 450 square feet per licensed bed

## Case Mix Rates

### Capital component - fair rental value (FRV)

- FRV system elements
  - Depreciation Rate = 1.25% a year
  - Maximum age = 30 years
  - Major renovations/bed additions reduce age quarterly
    - Minimum renovation of \$500 per bed
  - Minimum occupancy = 70%
  - Resident days used in per diem are based on base year occupancy percentage

## Case Mix Rates

### Capital component - fair rental value (FRV)

- FRV system elements
  - Rental factor – updated annually at July 1
    - 9.25% currently
    - Average 20 year Treasury Bond rate for the calendar year preceding the rate year plus a risk factor of 2.5%
    - Floor of 9.25%
    - Ceiling of 10.75%

## Case Mix Rates

### Example FRV Calculation

- Facility Data
  - Licensed beds 145
  - Weighted age 20
  - Total square feet 37,500
  - Total square feet per bed (37,500 / 145) 259
  - Allowable square feet per bed 300
  - Total allowable square feet (300\*145) 43,500
  - Total resident days 47,389

## Case Mix Rates

### Example FRV Calculation

- **Gross Facility Value**

New bed value ( $\$149.44 * 43,500$ )	\$6,500,640
Land value ( $\$14.96 * 43,500$ )	\$ 650,760
Moveable equipment ( $\$6,132 * 145$ )	<u>\$ 889,140</u>
Total gross facility value	<u><b>\$8,040,540</b></u>

## Case Mix Rates

### Example FRV Calculation

- **Depreciated Facility Value**

Depreciation rate (20 years * 1.25%)	25.00%
Depreciated bed value ( $75% * \$ 6,500,640$ )	\$4,875,480
Land value (not depreciated)	\$ 650,760
Depreciated moveable equip. value ( $75% * \$889,140$ )	<u>\$ 666,855</u>
Total depreciated facility value	<u><b>\$6,193,095</b></u>

## Case Mix Rates

### Example FRV Calculation:

Total depreciated facility value	\$6,193,095
Multiplied by rental rate	9.25%
Annual rental payment	<u>\$ 572,861</u>
Divided by total resident days or minimum occupancy (70% of total current licensed bed days)	47,389
<b>Fair rental value rate per diem</b>	<u><u>\$ 12.09</u></u>

## Case Mix Rates

### Capital component – fair rental value (FRV)

- Updating initial weighted age of a facility
  - Every July 1, the weighted age is increased by 1 year
  - The 1<sup>st</sup> day of every calendar quarter a re-aging of facilities will be done based on major renovations, improvements, and additions completed that exceed \$500 of capitalized cost per licensed bed
  - Re-age request must be submitted prior to the 1<sup>st</sup> day of each quarter (see suggested re-age form in Appendix V)

## Case Mix Rates

Capital component – fair rental value (FRV)

- Updating initial weighted age of a facility
  - All renovation, improvement, or bed additions must be related to the nursing facility licensed beds (as opposed to non-nursing facility areas)
  - All projects must be capitalized, completed, and placed in service within the previous 24 months prior to the request date

## Case Mix Rates

Capital component – fair rental value (FRV)

- Updating initial weighted age of a facility
  - A renovation / improvement will be used to reduce the age of a facility based on the cost of the renovation
  - A bed addition or replacement will be used to reduce the weighted age based on the number of new beds

## Case Mix Rates

Capital component – fair rental value (FRV)

- Updating initial weighted age of a facility
  - Major renovation / improvement requirements
    - Each renovation must exceed \$500 of capitalized expense per licensed bed
    - Expenses must all be directly related to a single renovation/improvement project
    - The project must be continuous
    - Memo sent out by DHH – see Appendix VI

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## Case Mix Rates

### Major Renovation Example

- Facts (carried over from FRV example)
  - Renovation of a nursing facility wing for \$250,000 was capitalized, completed, and placed into service
  - Current weighted age is 20 years
  - Allowable square footage per bed is 300
  - Current square footage value excluding land is \$149.44
  - Current bed value is \$6,132
  - The facility has 145 current licensed beds

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## Case Mix Rates

### Major Renovation Example

- Determine New Bed Equivalents

Square foot value in 2009 ( $\$149.44 * 300$  allowable sq. ft per bed)  $\$44,832$

Bed value in 2009	<u><math>\\$6,132</math></u>
Total facility bed value (excluding land)	$\$50,964$
Depreciation rate ( $20 * 1.25\%$ )	<u><math>25\%</math></u>
Accumulated depreciation per bed ( $\$50,964 * 25\%$ )	<u><math>\\$12,741</math></u>
New bed equivalents ( $\$250,000 / \$12,741$ )	<u><u><math>20</math></u></u>

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## Case Mix Rates

### Major Renovation Example

- Determine New Weighted Age (Re-Age)

	<u>Beds</u>	<u>Age</u>	<u>Sub-total</u>
Old Beds	125	x 20	2,500
New Beds	20	x 0	0
Total	<u>145</u>		<u>2,500</u>
New Age ( $2,500 / 145$ )			<u><u>17 years</u></u>

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# Questions?



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## Case Mix Rates

### Pass Through Rate Components

- Property taxes
- Property insurance
- Provider fees
- Rate adjustments

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## Case Mix Rates

### Pass Through Rate Components

- Property tax and insurance
  - The sum of the facility's per diem property tax and property insurance cost from the base year cost report trended forward
  - Important that it is properly reported on the Medicaid supplemental Schedule F, "Specific Cost Detail" schedule (line and amount)

## Case Mix Rates

### Pass Through Rate Components

- Property tax and insurance
  - Should not include liability or other non-property insurance amounts
  - Insurance and tax amounts should be properly charged to prepaid accounts

## Case Mix Rates

### Pass Through Rate Components

- Provider fees
  - Currently at \$8.02
- Rate adjustments
  - Rate adjustments may be made when determined necessary by the Secretary
  - In the event of a rate adjustment the facility specific direct care and care-related floor will be reduced by 1 percentage point for every decrease of \$0.30 of the rate adjustment. The floor cannot be decreased below 90%.

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## Case Mix Rates

### Leave of Absence Rates

- Rule is in Appendix X (§1321 *Louisiana Register Vol. 35, No. 09 September 20, 2009*).
- Effective March 1, 2009 Home and Hospital Leave of Absence rates are reimbursed using the same methodology.
- Nursing facilities with occupancy rates less than 90% will be reimbursed 10% of the applicable per diem rate in addition to the nursing facility provider fee.

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# Case Mix Rates

## Leave of Absence Rates (cont.)

- Nursing Facilities with occupancy percentages greater than or equal to 90% will be reimbursed at 90% of the applicable per diem rate in addition to the nursing facility provider fee.
- Occupancy percentages are determined from the average annual occupancy rate listed in the Louisiana Inventory of Nursing Home Bed Utilization Report (LTC-2) published from the period six months prior to the current rate quarter. The report is available on the DHH website.

# Case Mix Rates

## Leave of Absence Rates (cont.)

### Example Calculation

Louisiana Case Mix - Leave of Absence Rates  
Example Facility

Leave Rate Calculation for Provider With Less Than 90% Occupancy		Home / Hospital Leave
1. Nursing Facility Occupancy from LTC-2		80.00%
2. Nursing Facility Rate for Example Facility		130.07
3. Less: Provider Fee		(8.02)
4. Applicable Nursing Facility Per Diem Rate (Excluding Provider Fee) (Line 2 - Line 3)		122.05
5. Percentage of Per Diem Rate allowed for Leave of Absence Rates		10.00%
6. Applicable Per Diem rate reimbursed for Leave of Absence Rates (Line 4 * Line 5)		12.21
7. Provider Fee		8.02
8. Percentage of Provider Fee Allowed for Leave of Absence Rates		100.00%
9. Portion of Provider Fee reimbursed for Leave of Absence Rates		8.02
10. Total Leave of Absence Rate for Example Nursing Facility (Line 6 + Line 9)		20.23
Leave Rate Calculation for Providers with 90% or greater Occupancy		Home / Hospital Leave
11. Nursing Facility Occupancy from LTC-2		90%
12. Applicable Nursing Facility Rate (Including Provider Fee)		130.07
13. Percentage of Per Diem rate Allowed fro Leave of Absence Rates		90%
14. Total Leave of Absence Rate for Example Nursing Facility (Line 12 * Line 13)		117.06

# Questions?



## Application of DC / CR Spending Floor

- Applies to cost reports beginning on/after 1/1/2003
- A facility that does not spend the minimum floor percentage of 94% on direct care / care-related services, must refund Medicaid the difference between the floor and their actual spending
  - Specialized Care (ID/TDC) and NRTP expenditures are not included in the calculation of the spending floor.
- Actual direct care / care-related spending will be determined using audited / desk reviewed cost report data

## Application of DC / CR Spending Floor

- The cost report period direct care / care-related spending will be compared to the average all rate effective dates of floor amounts for that cost report period
  - The average of all rate effective date floor amounts will be weighted based on their number of days in the cost report period
- The floor recoveries by Medicaid will be calculated annually after audits / desk reviews are complete

## Application of DC / CR Spending Floor

### Example calculation:

Example Facility							
Cost Report Period 1/1/2007 to 12/31/2007							
	Rate Effective Date						Totals
	1/1/2007	2/1/2007	3/1/2007	4/1/2009	7/1/2007	10/1/2007	
Facility-specific floor amounts	\$ 43.90	\$ 46.80	\$ 47.96	\$ 46.51	\$ 48.77	\$ 50.10	
Days in Cost Report Period	31	28	31	91	92	92	365
	1,360.90	1,310.40	1,486.76	4,232.41	4,486.84	4,609.20	17,486.51
Day-weighted floor average (17,486.51 / 365 days)							\$ 47.91
Direct care / care-related cost per cost report							\$ 1,121,610
Total resident days per cost report (excluding specialized care)							24,120
Total direct care / care-related cost per diem							\$ 46.50
Per diem amount to be repaid to Medicaid							\$ 1.41
Total Medicaid days paid from 1/1/2007 to 12/31/2007							20,715
Total to be repaid to Medicaid							\$ 29,208

## Application of DC / CR Spending Floor

- Beginning with cost report periods ending on/after 6/30/08, the spending floor calculation is included on Schedule J of the Medicaid Supplemental Cost Report Excel Template.
- Schedule J will be recalculated after audit/desk review. Currently Schedule J is considered a preliminary floor calculation.
- Myers and Stauffer will recalculate the floor and send to the State of Louisiana. The State will then proceed to issue floor billings to provider if applicable.

Myers and Stauffer  
Chartered Public Accountants

STATE of LOUISIANA

## Questions?



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## Special Program Rate Calculations

### Fire Sprinkler System and Two-Hour Rated Wall Reimbursement

- Rule is in Appendix X (*§1317, Louisiana Register Vol. 32, No. 12 December 20, 2006*)
- Fire Sprinkler System reimbursement is paid over 5 year period as a pass-through for the Medicaid portion.

## Special Program Rate Calculations

### Fire Sprinkler System and Two-Hour Rated Wall Reimbursement Qualifications

- All nursing facilities were required to be protected throughout by a fire sprinkler system by January 1, 2008.
- A completed fire sprinkler system plan or two-hour rated wall plan, or both must have been submitted for approval by December 31, 2006
- After approval and installation was completed facilities must submit auditable depreciation schedules and invoice to support cost. Cannot be included as part of capital re-age.

## Special Program Rate Calculations

### Bed Buy Back Program

- 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 an incentive payment for five years after the legal transfer of ownership and closure of the seller's nursing facility.
- Rule is in Appendix X (§1312 *Louisiana Register Vol. 34, No. 06 June 20, 2008*)

## Special Program Rate Calculations

### Bed Buy Back Program

- Qualifications
  - Buyer(s) must purchase a Medicaid-certified nursing facility (Seller)
  - Close the purchased NF within 90 days after the legal transfer of ownership

## Special Program Rate Calculations

### Bed Buy Back Program

- Qualifications (cont.)
  - Permanently surrender their interest in the seller's bed license and the Facility Need Review bed approvals to the state
  - The buyer(s) must be a Medicaid-certified nursing facility operator(s) at the time of purchase and continue their Medicaid participation throughout the entire five year payment period

## Special Program Rate Calculations

### Bed Buy Back Program

- Documentation
  - The buyer(s) must provide all documentation to the Department of Health and Hospital, Rate and Audit Review
  - All documentation is in addition to current documentation required by Health Standards and other divisions for change of ownerships

## Special Program Rate Calculations

### Bed Buy Back Program

- Documentation
  - Within 30 days of the legal transfer of ownerships
    - A list of all buyers
    - A list of all sellers
    - The date of legal transfer of ownership
    - Each buyer's share of the purchased facility
    - Each buyer's current resident listing and total occupancy calculation as of the date of legal transfer of ownership

## Special Program Rate Calculations

### Bed Buy Back Program

- Documentation
  - Within 110 days of the legal transfer of ownerships
    - A list of the NF 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 date that the seller's facility was officially closed and no longer operating as a nursing facility.

# Special Program Rate Calculations

## Bed Buy Back Program

- Incentive Calculations
  - Begins with base Medicaid capital amounts published in rule
  - Base Medicaid capital amounts are updated every July 1 based on the same RS Means update used for the Fair Rental Value components
  - Updates to the base Medicaid capital amounts only apply to transactions on/after the update date (July 1) and do not impact prior transactions
  - The base Medicaid capital amount does not get updated at any time after a bed buy back is completed (stays the same for the entire 5 years)



STATE of LOUISIANA

# Special Program Rate Calculations

## Bed Buy Back Program

- Incentive Calculations
  - Base Medicaid Capital Amount depends on beds surrendered from the closed facility

Effective Date	Beds Surrendered		
	Under 115 Beds Base Amount	115-144 Beds Base Amount	145 Beds or More Base Amount
Per Original Rule	\$ 303,216	\$ 424,273	\$ 597,591
7/1/2008	\$ 320,893	\$ 449,220	\$ 632,431
7/1/2009	\$ 343,484	\$ 480,845	\$ 676,954 *

\* The 7/1/2009 amounts were calculated based on the original rule amounts updated for the appropriate RS Means increase. These amounts are only applicable to transactions that occur on/after 7/1/2009.



STATE of LOUISIANA

## Special Program Rate Calculations

### Bed Buy Back Program

- Incentive Calculations
  - Base Medicaid Capital Amount is Multiplied by a percentage factor
  - The percentage factor is determined based on the cumulative occupancy increase of all buyers

## Special Program Rate Calculations

### Bed Buy Back Program

- Incentive Calculations
  - Percentage of the Base Medicaid Capital Amount is determined as follows:

Cumulative Occupancy Increase % for all Buyers	Base Payment %
Under 5.00%	67.00%
5.00% through 9.99%	78.00%
10.00% through 14.99%	89.00%
15.00% and Up	100.00%

## Special Program Rate Calculations

### Bed Buy Back Program

- Incentive Calculations
  - 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 by the buyers.

## Special Program Rate Calculations

### Bed Buy Back Program

- Incentive Calculations
  - The per diem incentive payment will be calculated as the buyer's share of the annual Medicaid incentive payment divided by annual Medicaid days.
  - Annual Medicaid days will be equal to Medicaid residents transferred from the seller facility multiplied by total current rate year days plus the buyer's annualized Medicaid days from the most recent base year cost report.

## Special Program Rate Calculations

### Bed Buy Back Program

- Restatement of FRV and Property Tax/Insurance Per Diems
  - All buyers will have their fair rental value, property tax, and property insurance per diems re-based using the number of transferred residents reported by each buyer. The re-base will be retroactive to beginning of the month following the date of closure of the purchased facility.

## Special Program Rate Calculations

### Bed Buy Back Program

- Rebase Per Diems
  - At each rebase, the per diem incentive amounts, FRV, and property tax / insurance will be restated based on the census data from the cost report

## Special Program Rate Calculations

### Bed Buy Back Program

- Example Calculation
  - A complete example of the bed buy back is included in [Appendix VIII](#)

## Special Program Rate Calculations

### Private Room Conversions

- Rule is included in Appendix X ([§1310, Louisiana Register Vol. 33, No. 08 August 20, 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.

## Special Program Rate Calculations

### Private Room Conversions

- Qualifications
  - The nursing facility must convert one or more semi-private rooms to private rooms on or after September 1, 2007.
  - The converted private rooms must be occupied by Medicaid residents to receive the \$5 incentive payment.
  - The nursing facility must surrender their bed licenses equal to the number of converted private rooms.

## Special Program Rate Calculations

### Private Room Conversions

- Documentation to be submitted to the Department of Health and Hospitals-Rate and Audit Review within 30 days of the private room conversion:
  - The number of rooms converted to Medicaid private rooms
  - The number of beds de-licensed in the conversion of the Private rooms
  - A resident listing by payer type for the converted private rooms
  - The date of the actual conversions in license

## Special Program Rate Calculations

### Private Room Conversions

- Documentation to be submitted to the Department of Health and Hospitals-Rate and Audit Review within 30 days of the private room conversion (cont.):
  - The date each patient was placed in the private room
  - A copy of revised license when received from Health Standards
    - Note: Rate and Audit Review will receive notification from Health Standards which will serve as notification of license change until such time the provider is able to obtain and forward the new license to Rate and Audit Review

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## Special Program Rate Calculations

### Private Room Conversions

- Payment of \$5 Incentive Per Diem
  - The nursing facility will bill using Revenue Code 119 for the number of days the Medicaid recipient occupied the private room.
  - An additional \$5 will be added to the nursing facility's case-mix rate for each Medicaid resident day in a converted private room.
    - The facility will not be reimbursed the additional \$5 for those days the recipient is on hospital or bed hold leave
  - The payment will begin the first of the following calendar quarter, after the facility meets all qualifying criteria.
  - A change in ownership, major renovation, or replacement facility will not impact the \$5 additional per diem payment provided that all other provisions of the rule have been met.

Myers and Stauffer  
Chartered Public Accountants

STATE of LOUISIANA

## Special Program Rate Calculations

### Private Room Conversions

- Rebase of Fair Rental Value Per Diem
  - The calculation of the revised fair rental value per diem after a private room conversion can be complex
  - The rules cover three different square footage scenarios
  - Additional renovations (re-ages) can add further complexity to the calculation
  - Each rebase presents more complexity
  - An example calculation with several scenarios is included in [Appendix IX](#)

## Special Program Rate Calculations

### Private Room Conversions

- Rebase of Fair Rental Value Per Diem
  - Even with the complexity, it is easier if we keep in mind the goals of the rebase of the FRV per diem:
    1. Keep total allowable square footage the same as it was prior to the conversion so the provider is not penalized for the conversion
      - Exception would be where a completely new building is built.
    2. Adjust occupancy used in the per diem to account for empty beds that were removed from service
      - Assumes all beds removed in conversion were empty beds.

## Special Program Rate Calculations

### Private Room Conversions

- Rebase of Fair Rental Value Per Diem
  - The revised fair rental value per diem will be effective the first of the following calendar quarter, after the facility meets all qualifying criteria

## Budgetary Adjustments

- Based on the Emergency rule that will be published in the February 20, 2010 Louisiana Register, effective for dates of service on or after January 22, 2010, the reimbursement paid to non-state nursing facilities shall be reduced by 1.5 percent of the case-mix statewide Medicaid-day weighted average per diem rate excluding provider fee, on file as of January 21, 2010. This budgetary adjustment is \$1.95 per day.
- A Notice of intent dated November 20, 2009 states that there will be a 10.52% budgetary adjustment effective July 1, 2010.

Questions?



Myers and Stauffer

STATE of LOUISIANA

# **APPENDIX I**

## **ELECTRONIC POSTING OF CMI MEMO**



**State of Louisiana**  
Department of Health and Hospitals  
Bureau of Health Services Financing

**MEMORANDUM**

**TO: ADMINISTRATORS OF NURSING FACILITIES**

**FROM: KENT BORDELON, DIRECTOR  
RATE & AUDIT REVIEW**

A handwritten signature in cursive script, appearing to read "Kent Bordelon".

**SUBJECT: ELECTRONIC POSTING OF CMI REPORTS**

**DATE: DECEMBER 9, 2008**

Dear Administrator,

As you know, The Department of Health and Hospitals implemented a new process for communicating case mix reports by means of electronically posting the reports to your sub-directory on the CMS MDS server. This process began on May 29, 2008 with the electronic posting of the point in time 4/1/08 Preliminary CMI Reports. During the transition to this new process, your CMI reports have continued to be mailed to you through the U.S. Postal service as well as being posted electronically.

The reports are being posted to a sub-directory within your CMS MDS validation report directory. To access this directory you must connect to the CMS MDS submission web page using your MDCN connection (broadband or dial up) just as if you are going to transmit an MDS submission file. The Preliminary Case Mix Index Reports are posted to your CMS MDS validation report directory around the 16<sup>th</sup> of the second month following the end of each quarter (February, May, August and November). The Final Case Mix Index Reports are posted to your CMS MDS validation report directory around the 16<sup>th</sup> of the third month following the end of each quarter (March, June, September and December). Please refer to the following pages that include detailed instructions for obtaining your Preliminary and Final Case Mix Index Reports.

**This is a reminder that beginning in 2009 the paper copies of the reports will no longer be mailed.** We encourage you to go to the webpage to retrieve your electronic

Administrator  
December 9, 2008  
Page 2

version of the reports. The reports are archived by the CMS MDS system every 90 days, therefore to retain these reports for your files please save them to a directory on your local computer and/or print the reports for your records.

Should you have any questions please contact the Myers and Stauffer help desk at 1-800-763-2278.

KB:cq

Attachment

cc: Greg Cecil, Myers & Stauffer, LC  
Lana Ryland, Rate & Audit Review  
Mark Berger, LNHA

# **Louisiana Department of Health and Hospitals**

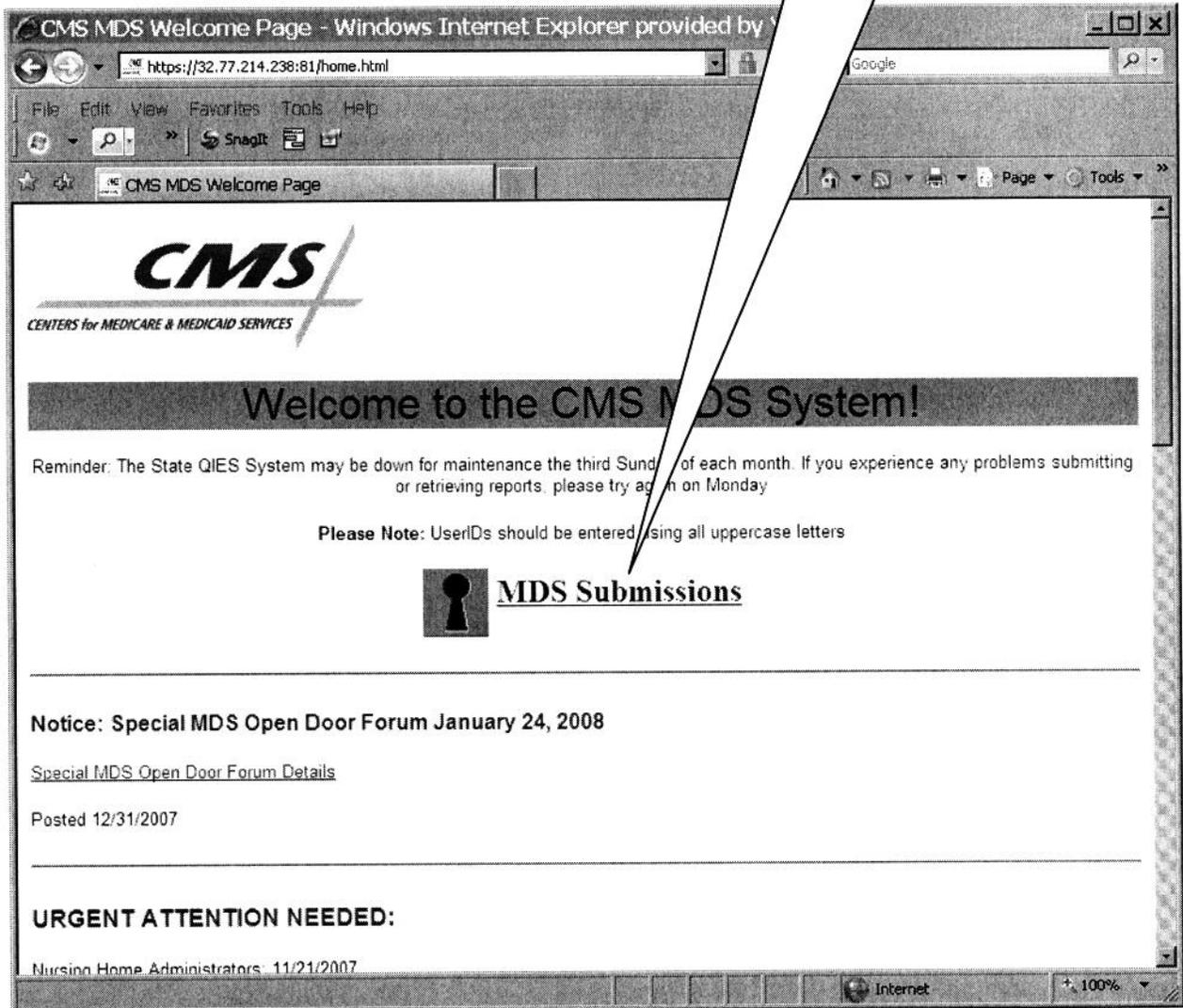
## **Electronic Transmission of Case Mix Index Reports**

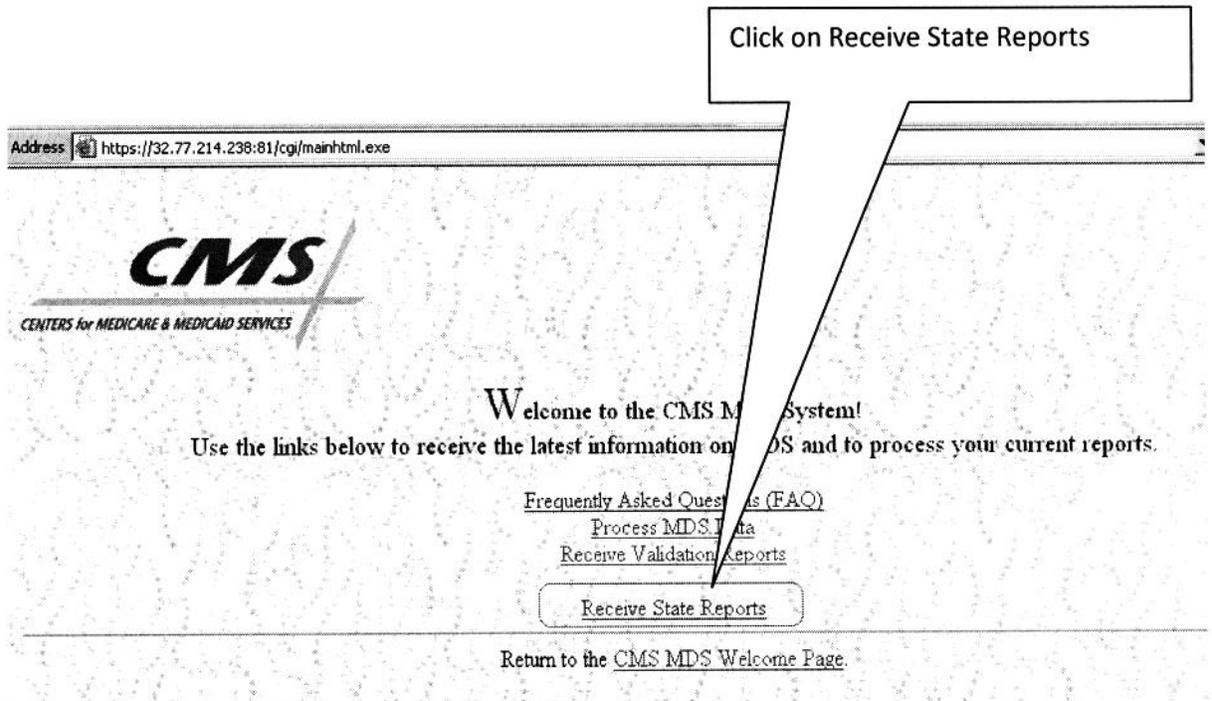
Instructions

Dated: December 1, 2008

Connect to the CMS MDS submission web page using your MDCN connection (broadband or dial up) as if you are going to transmit an MDS submission file.

Click on MDS Submissions.





This folder will contain your Preliminary and Final Case Mix Index Reports.

The reports will be identified using the following naming convention rules:  
The name will begin with your facility's loginid assigned by the Department of Health and Hospitals, followed by the quarter and year and then the version of the report.

For example:

LOGINID\_Q408\_PRE (This is a report for 1/1/09 and it is the Preliminary version)

LOGINID\_Q408\_FIN (This is a report for 1/1/09 and it is the Final version)

The reports are archived by the CMS MDS system every 90 days, therefore to retain these reports for your files please save them to a directory on your local computer and/or print and file the reports.

# **APPENDIX II**

## **BLANK CMI LISTING**

# LOUISIANA CASE MIX SYSTEM

## Preliminary Case Mix Index Report

Point In Time Date 10/01/2008

Provider Number: 55555

Print Date: 11/14/2008

Provider Name: Facility B

Page 1 of 4

Resident Name	Resident ID	AA8a, b	Effective Date (R2b)	RUG Code	ADL Score	Note(s)	Index	Payment Source
	05		08/21/2008	RAA	4		1.0700	Medicaid
	05		08/14/2008	SSA	10		1.2800	Medicaid
	02		09/25/2008	SSC	18		1.4400	Other
	02		07/17/2008	IA1	4		0.6700	Medicaid
	05		07/17/2008	CB2	16		1.1500	Medicaid
	05		08/07/2008	SSA	14		1.2800	Medicaid
	05		09/18/2008	SSC	18		1.4400	Medicaid
	05		08/14/2008	CC1	18		1.2500	Medicaid
	02		08/01/2008	CB1	14		1.0700	Medicaid
	05		09/30/2008	RAA	9		1.0700	Medicaid
	05		08/07/2008	PB1	8		0.6300	Medicaid
	05		09/04/2008	IB2	9		0.8800	Other
	05		07/24/2008	IA1	4		0.6700	Medicaid
	05		07/24/2008	PB2	6		0.6500	Medicaid
	05		08/28/2008	IB1	8		0.8500	Medicaid
	02, 1		09/03/2008	IA1	4		0.6700	Medicare
	05		07/17/2008	PA1	4		0.5900	Medicaid
	05		09/18/2008	CC1	18		1.2500	Medicaid
	05		09/25/2008	CC2	18		1.4200	Medicaid
	09		09/17/2008	RAA	4	A	1.0700	Medicaid
	09		09/11/2008	CA1	6	A	0.9500	Other
	05		08/28/2008	IA1	4		0.6700	Medicaid
	05		08/07/2008	PD1	11		0.8900	Medicaid
	05		09/11/2008	RAA	4		1.0700	Other
	05		09/11/2008	PA1	4		0.5900	Other
	09		08/11/2008	CC1	17	A	1.2500	Medicare
	05		07/17/2008	IA1	4		0.6700	Medicaid
	05		09/25/2008	SSB	16		1.3300	Medicaid
	05		08/21/2008	PD1	14		0.8900	Medicaid
	03		08/14/2008	IB1	9		0.8500	Medicaid
	05		09/04/2008	PE1	18		0.9700	Other
	05		09/18/2008	CC1	18		1.2500	Medicaid
	03		08/05/2008	CB1	16		1.0700	Medicaid
	05		09/11/2008	RAA	8		1.0700	Other
	02		09/04/2008	CB1	16		1.0700	Medicaid
	00, 7		09/30/2008	RAB	12		1.2400	Medicare
	05		08/07/2008	IA1	4		0.6700	Other
	02		08/28/2008	CB1	16		1.0700	Medicaid
	05		08/14/2008	IB2	8		0.8800	Medicaid
	05		07/24/2008	PB2	8		0.6500	Medicaid
	00, 3		09/17/2008	RAC	16		1.3100	Medicare
	05		08/14/2008	IA1	4		0.6700	Medicaid

# LOUISIANA CASE MIX SYSTEM

## Preliminary Case Mix Index Report

Point In Time Date 10/01/2008

Provider Number: 55555

Provider Name: Facility B

Print Date: 11/14/2008

Page 4 of 4

### RUG Distribution Totals

Extensive Services	0
Rehabilitation	29
Special Care	15
Clinically Complex	19
Impaired Cognition	31
Behavior Problems	0
Reduced Physical Function	31
Delinquent (BC1)	0
<hr/>	
Total Residents	125

### Total Residents and CMI Averages

Medicaid Residents	89	0.9645
Medicare Residents	17	1.1776
Other Residents	19	0.9032
<hr/>		
All Residents	125	0.9842

### Notes:

A. This reentry form is preceded with an assessment that is active and is assigned the RUG-III code applicable to the preceding assessment.

# **APPENDIX III**

## **SAMPLE MEDICAID SUPPLEMENTAL COST REPORT**

State of Louisiana  
Department of Health and Hospitals  
Nursing Facility (NF) Medicaid Cost Report

**INSTRUCTIONS FOR FILING:**

- 1 **Within 5 months of cost report period end**, submit the documents on Schedule L in either electronic format (scanned if possible) or paper copy.
- 2 **Within 5 months of cost report period end**, E-mail a copy of the completed NF Medicaid cost report Excel template, the Medicare cost report ECR file, and the Medicare Home Office Cost Statement to Myers and Stauffer.

*All electronic documentation should be e-mailed to Myers and Stauffer at:*

[LANF@mslc.com](mailto:LANF@mslc.com)

Electronic Files Should be Named in the following example formats:

**Medicare ECR File:**

Use the format required by your Medicare software (Should be "SN"+ provider number + year)

**Medicaid Cost Report File** ("NH" + provider # + Home Office Name + Facility Name + "As Filed cost report" + Year End in "yyyymmdd" format):

*NH 55555 ABC Management Co, Inc. - DEF Nursing Home As filed cost report 20081231.pdf*

**If You Have One Attachment File** ("NH" + provider # + Home Office Name + Facility Name + "attachments" + Year End in "yyyymmdd" format):

*NH 55555 ABC Management Co, Inc. - DEF Nursing Home CR attachments 20081231.pdf*

**If You Have Multiple Attachment Files** ("NH" + provider # + Home Office Name + Facility Name + "attachments" + Year End in "yyyymmdd" format + description + sequence # ):

*NH 55555 ABC Management Co, Inc. - DEF Nursing Home CR attachments 20081231 WTB-1.pdf (or .xls)*

*NH 55555 ABC Management Co, Inc. - DEF Nursing Home CR attachments 20081231 PS&R-2.pdf*  
etc...

*All paper documentation can be mailed (using certified or other traceable delivery) or faxed to:*

**Myers and Stauffer**  
ATTN: Louisiana NF  
11440 Tomahawk Creek Parkway  
Leawood, Kansas 66211  
Fax: (913) 234-1104  
Phone: (800) 374-6858

- 3 **Make a back-up copy of your electronic cost reports and retain for future reference.**
- 4 **This cost report must be completed by all Medicaid-certified nursing facilities and their related home offices.**

**Please Call Myers and Stauffer at 1-800-374-6858 if you have any questions on using the template or filing the cost report.**

**LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS  
BUREAU OF HEALTH SERVICES FINANCING  
Nursing Facility Medicaid Cost Report**

**SCHEDULE A - FACILITY INFO**

**Read Instructions before completion. ALL FORMS AND SECTIONS SHOULD BE SUBMITTED, EVEN IF NOT APPLICABLE. ALL AMOUNTS SHOULD BE REPORTED IN WHOLE DOLLARS**

**WARNING:** While the Medicare cost report may allow more than one option for classifying costs, Medicaid will only recognize costs in a rate and floor component based on the case mix cross-walk shown on the Case Mix Cross-Walk Tab of this workbook. If a facility chooses to classify cost on their Medicare cost report in a manner that excludes that cost from their direct care or care-related rate component and floor, then the cost will forever be excluded from the direct care and care-related rate and floor, unless adjusted at audit or desk review. If there are any questions related to the cross-walk, please contact DHH or Myers and Stauffer for clarification.

Medicaid Provider Number: 5555 Medicare Number: 19-9999 Certification Date: 7/1/1996

Cost Report Period: From: 1/1/2007 To: 12/31/2007 Date Completed:

Facility Name as Shown on Certification: Facility B

Street Address: 999 N. Main Street

City: Baton Rouge State: LA Zip: 77777

Contact Person: Glen Dorsey Phone: (225) 225-2252 Ext:

Email: gdorsey@anytown.com Fax: (225) 225-2253 Ext:

**A. TYPE OF CONTROL (Select Only One)**

<p align="center"><u>Nonprofit</u></p> <p><input type="checkbox"/> Church Related</p> <p><input type="checkbox"/> Private</p> <p><input type="checkbox"/> Other (specify) <u></u></p>	<p align="center"><u>Proprietary</u></p> <p><input type="checkbox"/> Individual</p> <p><input type="checkbox"/> Partnership</p> <p><input checked="" type="checkbox"/> Corporation</p>	<p align="center"><u>Governmental</u></p> <p><input type="checkbox"/> State</p> <p><input type="checkbox"/> Parish</p> <p><input type="checkbox"/> City</p> <p><input type="checkbox"/> Other (specify) <u></u></p>
---	--	---

**B. TYPES OF SERVICES PROVIDED (Select All That Apply)**

- Nursing Facility (NF)
- Skilled Nursing Infectious Disease (SN/ID)
- Skilled Nursing Technology Dependent Care (SN/TDC)
- Neurological Rehabilitation Treatment Program (NRTP-Rehab)
- Neurological Rehabilitation Treatment Program (NRTP-Complex)

**C. TYPE OF FACILITY (Select Only One)**

- Free-Standing Nursing Facility (NF)
- Free-Standing Skilled Nursing Facility/Nursing Facility (SNF/NF) - Medicare/Medicaid
- Hospital-Based Nursing Facility (NF)
- Hospital-Based Skilled Nursing Facility/Nursing Facility (SNF/NF) - Medicare/Medicaid

**LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS  
BUREAU OF HEALTH SERVICES FINANCING  
Nursing Facility Medicaid Cost Report**

PROVIDER: Facility B

5555

FROM: 1/1/2007

TO: 12/31/2007

**SCHEDULE B - STATISTICAL DATA**

	<b>Licensed</b>	<b>Medicare/Medicaid Certified</b>	<b>Title XIX Converted Private Rooms Approved Under LAC 50:VII.1310</b>
	<i>(a)</i>	<i>(b)</i>	<i>(c)</i>
1. Beds (beginning of period)	145	143	
1.01 Change in number of beds			
1.02 Date of Change			
2. Beds (end of period)	145	143	0
3. Total Available Bed Days <i>(number of beds X number of days in cost report period)</i>	52,925	52,195	

	<b>Title XVIII</b>	<b>Title XIX excl. SN/ID SN/TDC &amp; NRTP*</b>	<b>Title XIX SN/ID</b>	<b>Title XIX SN/TDC</b>	<b>Title XIX NRTP*</b>	<b>Other</b>	<b>Total Days</b>	<b>Allowable Leave Days</b>	<b>Paid Bed Hold Days</b>	<b>Provider Fee Bed Days</b>
	<i>(a)</i>	<i>(b)</i>	<i>(c)</i>	<i>(d)</i>	<i>(e)</i>	<i>(f)</i>	<i>(g)</i>	<i>(h)</i>	<i>(i)</i>	<i>(j)</i>
4. Inpatient Days	3,964	35,289		4,121		4,015	47,389	533	428	48,350
5. Percent of Total	8.36%	74.47%	0.00%	8.70%	0.00%	8.47%	100.00%			
6. Total XIX Days paid/Payable at end of period <i>(should equal line 4, TOTALS, cols b - e)</i>		35,289	0	4,121	0		39,410			
7. Percentage Occupancy (Line 4 Total Days/Line 3 Licensed Bed Days)							89.54%			
8. Total Title XIX Inpatient Private Room Days under Private Room Conversion Rule, LAC 50:VII.1310 (corresponds to beds on lines 1-3, col. (c), above) (Should NOT include any leave days)							90			

\*NRTP Includes both NRTP-Rehab and NRTP-Complex

\*\*This total should agree to total days on Worksheet S-3 of your Medicare cost report.

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**SCHEDULE C - OWNERSHIP / EMPLOYEES / RELATED PARTIES**

1. List all persons living in facility who are not residents, their position or relationship to the facility such as owners, employees, etc.

Name <i>(a)</i>	Function <i>(b)</i>	Hours per work week devoted to business <i>(c)</i>	% of ownership <i>(d)</i>	Compensation included in allowable costs for this period <i>(e)</i>

2. Changes in ownership, licensure or certification during period. Attach a copy of change notification to State and/or approval for change.

Type of Change <i>(a)</i>	From <i>(b)</i>	To <i>(c)</i>	Date of Change <i>(d)</i>

3. If the facility is leased, give full name of the owners of the leased assets, disclose whether the lessor is a related party, and disclose the lease rate per month. Attach a copy of the executed lease agreement effective during the cost report period.

Owner of Leased Assets <i>(a)</i>	Related Party (Yes/No?) <i>(b)</i>	Lease Rate Per Month <i>(c)</i>

4. If motor vehicles are leased, give full name of the owners of the leased assets, disclose whether the lessor is a related party, and disclose the lease rate per month. Attach a copy of the executed lease agreement effective during the cost report period.

Owner of Leased Assets <i>(a)</i>	Related Party (Yes/No?) <i>(b)</i>	Lease Rate Per Month <i>(c)</i>

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SCHEDULE C - OWNERSHIP / EMPLOYEES / RELATED PARTIES		

5. List all owners with 5% interest or more and/or members of the Board of Directors and key officers even if they receive no compensation, and provide the following information.

Name <i>(a)</i>	Function <i>(b)</i>	Hours per week devoted to nursing facility business <i>(c)</i>	Percent of Ownership <i>(d)</i>	Compensation Included in Allowable Costs for the Period <i>(e)</i>
Glen Dorsey	President		100%	\$ 97,522

6. List all relatives of owners, members of Board of Directors and key officers (listed in #5 above) employed by the facility.

Name <i>(a)</i>	Function <i>(b)</i>	Relationship <i>(c)</i>	Related Owner # <i>(d)</i>	Compensation Included in Allowable Costs for the Period <i>(e)</i>
D. Bowe	Administrator	Brother	1.00	
T. Jackson	Asst. Administrator	Brother	1.00	



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**SCHEDULE D - MISCELLANEOUS INFORMATION**

8. Name of management company: Anytown Management  
Street Address: 1000 Maint St.  
City / State / Zip: Baton Rouge LA 77777

9. Name of accountant:  
Street Address:  
City / State / Zip:

10. Location of records:  
10.01 Financial: Anytown Management, 1000 Main St.,Baton Rouge, LA 77777  
10.02 Statistical: Anytown Management, 1000 Main St.,Baton Rouge, LA 77777  
10.03 Medical:  
10.04 Other:

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**SCHEDULE E-1 - NURSE AIDE TRAINING AND TESTING**

1. How Many Individuals Attended Nurse Aide Training and Testing During the Cost Report Period? 2
2. Out of All the Attendees, How Many Actually Passed the Course and Became CNAs? 1

**NAT&T EXPENSE**

DESCRIPTION <i>(a)</i>	EXPENSES PER BOOKS <i>(b)</i>	ADJUSTMENTS <i>(c)</i>	ALLOWABLE PROGRAM EXPENSE <i>(d)</i>	WORKSHEET A MEDICARE COST REPORT		
				LINE NO* <i>(e)</i>	DESCRIPTION <i>(f)</i>	COLUMN <i>(g)</i>
3. Salaries and Wages - Instructor Only	4,531		4,531	9.00	Nursing Administration	Salary
4. Payroll Taxes - Instructor Only	907		907	3.00	Employee Benefits	Other
5. Employee Benefits - Instructor Only			0			
6. Training Supplies			0			
7. Training Equipment Depreciation <i>(Attach Schedule)</i>			0			
8. Testing Fees	453		453	9.00	Nursing Administration	Other
9. Contract or Outside Services			0			
10. Miscellaneous (Specify)			0			
11. Miscellaneous (Specify)			0			
12. Miscellaneous (Specify)			0			
13. TOTAL EXPENSES (Add Lines 3-12)	\$ 5,891	\$ -	\$ 5,891			

14. Percent Of Medicaid Resident Days During Cost Reporting Period 82.6122%
15. Gross Medicaid Expense Allocation (Line 13 X Line 14) \$ 4,867
16. Medicaid Maximum Allowable Cost \$ 9,396
17. Enter The Lesser Of Line 15 Or Line 16 \$ 4,867
18. Amount Carried Forward From Prior Year \$ -
19. If Line 17 Is Greater Than Line 18, Enter Amount Due From Medicaid \$ 4,867
20. If Line 18 Is Greater Than Line 17, Enter Carried Forward Amount \$ -

**ADJUSTMENTS TO BE MADE BY RATE-SETTING (PROVIDERS DO NOT COMPLETE)**

Line #	Line Description	Column	As-Submitted Amount
21.	9.00 Nursing Administration	Salary	\$ (3,743)
22.	3.00 Employee Benefits	Other	\$ (749)
23.			\$ -
24.			\$ -
25.			\$ -
26.	9.00 Nursing Administration	Other	\$ (374)
27.			\$ -
28.			\$ -
29.			\$ -
30.			\$ -
31.	TOTAL		\$ (4,867)

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**SCHEDULE E-2 - NURSE AIDE TRAINING DETAIL**

**EXPENSE DETAIL**

- 1. NUMBER OF INSTRUCTORS:
- 2. FULL TIME EQUIVALENT:
- 3. BENEFITS PROVIDED: *NOTE: Benefits may not exceed those available to other employees*
  - 3.01 LIFE INSURANCE
  - 3.02 HEALTH INSURANCE
  - 3.03 RETIREMENT PLAN
  - 3.04 UNIFORMS
  - 3.05 MEALS
  - 3.06 OTHER (Describe)

Below, Explain Any Miscellaneous Expenses Shown on Schedule E-1, Lines 10-12

- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.

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**SCHEDULE F - SPECIFIC COST DETAIL**

**NOTE: Medicare Cost Report Worksheet A line number should be the line number after Worksheet A-6 reclassifications, if any.**

Indicate where the following expenses are recorded in your general ledger, and where they have been reported on Worksheet A of your Medicare cost report (after W/S A-6 Reclassifications, W/S A-8 and W/S A-8-1 Adjustments).

**F-1: INFORMATION FOR LOUISIANA MEDICAID RATE-SETTING**

Description (a)	GL Account # (b)	Dollar Amount (c)	Worksheet A Medicare Cost Report Line Number (d)	Worksheet A Description (e)	Worksheet A Medicare Cost Report Column (f)
1.00 Property Taxes	7100.00	19,838	1.00	Cap Rel Costs - Bldgs & Fixtures	Other
1.01 Property Taxes (if on more than one Worksheet A Line)					
2.00 Property Insurance	7098.00	35,216	1.00	Cap Rel Costs - Bldgs & Fixtures	Other
2.01 Property Insurance (if on more than one Worksheet A Line)					
3.00 Contract Nursing Services*	6400.00	16,828	16.00	Skilled Nursing Facility	Other
3.01 Contract Nursing Services* (if on more than one Worksheet A line)					
4.00 Raw Food	6700.00	228,407	8.00	Dietary	Other
5.00 Provider Fees	7200.00	351,897	4.00	Administrative & General	Other
6.00 Total Employee Benefits Included Directly in Skilled Nursing Facility Cost Center (From Line 16 on Medicare W/S A)			16.00	Skilled Nursing Facility	Other
6.01 Total Employee Benefits Included Directly in Nursing Facility Cost Center (From Line 18 on Medicare W/S A)			18.00	Nursing Facility	Other
<b>Total</b>		<b>\$ 652,186</b>			

\*RN, LPN and Aides direct patient care services obtained from outside staffing companies

For the two sections below, please provide documentation to support all information reported, such as payroll journals, etc. The information provided below should be on the accrual basis for the cost report period.

**F-2: SALARY INFORMATION - ADMINISTRATOR SECTION**

Description (a)	GL Account # (b)	Dollar Amount (c)	Worksheet A Medicare Cost Report Line Number (d)	Worksheet A Description (e)	Worksheet A Medicare Cost Report Column (f)
1.00 Salary	7150.00	100,100	4.00	Administrative & General	Salary
2.00 Bonuses					
3.00 Other Benefits					
4.00 Total Compensation (1+2+3)		\$100,100			
5.00 Medicaid Cost Report Adjustments					
6.00 Allowable Compensation (4+5)		\$100,100			
7.00 Administrator Name	D. Bowe			Related Party?	YES
8.00 Administrator Name				Related Party?	

**F-3: SALARY INFORMATION - ASSISTANT ADMINISTRATOR SECTION**

Description (a)	GL Account # (b)	Dollar Amount (c)	Worksheet A Medicare Cost Report Line Number (d)	Worksheet A Description (e)	Worksheet A Medicare Cost Report Column (f)
1.00 Salary	7160.00	56,160	4.00	Administrative & General	Salary
2.00 Bonuses	7165.00	541	4.00	Administrative & General	Salary
3.00 Other Benefits					
4.00 Total Compensation (1+2+3)		\$56,701			
5.00 Medicaid Cost Report Adjustments					
6.00 Allowable Compensation (4+5)		\$56,701			
7.00 Assistant Administrator Name	T. Jackson			Related Party?	YES
8.00 Assistant Administrator Name				Related Party?	

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**SCHEDULE G - ANCILLARY/THERAPY CHARGES**

1. Number of Medicaid residents without Medicare Part B coverage	26
2. Number of Medicaid residents without Medicare Part B coverage requiring therapy (PT, OT, ST)	5

*Below, record ancillary/therapy charges by payor source for all of the categories reported on Worksheet C of your Medicare cost report. Line items and totals should agree with Worksheet C of your Medicare cost report. The charges reported below should reflect only the charges for cost incurred by the facility and not any charges billed by an outside vendor for services the outside vendor provided.*

*\*Medicaid charges should include Medicaid charges for specialized services. If specialized services are provided (SN/ID, SN/TDC, NRTP), complete Schedules H-1, H-2, & H-3.*

*\*\*Nursing facility charges include charges for both the nursing facility and, where applicable, the skilled nursing facility unit.*

Ancillary / Therapy Line Number Per Medicare Cost Report (a)	Ancillary / Therapy Cost Center Category Per Medicare Cost Report (b)	Nursing Facility / Skilled Nursing Facility Only**				All Other Routine Cost Center Charges (g)	Worksheet C Total (h)
		Medicare Part A Charges (c)	Medicare Part B Charges (d)	Medicaid Charges* (e)	Other Charges (f)		
3.	22.00 Laboratory	68,737		6,680			\$ 75,417
4.	23.00 Intravenous Therapy	56,534					\$ 56,534
5.	25.00 Physical Therapy	515,882	392,754	411			\$ 909,047
6.	26.00 Occupational Therapy	389,651	199,817	305			\$ 589,773
7.	27.00 Speech Pathology	239,586	84,063	3,352			\$ 327,001
8.	29.00 Medical Supplies Charged To Patients	41,107	174,979	339,417			\$ 555,503
9.	30.00 Drugs Charged To Patients	328,088					\$ 328,088
10.							\$ -
11.							\$ -
12.							\$ -
13.							\$ -
14.							\$ -
15.							\$ -
16.							\$ -
17.							\$ -
18.							\$ -
19.							\$ -
20.							\$ -
21.							\$ -
22.							\$ -
23.							\$ -
24.							\$ -
25.							\$ -
26.							\$ -
27.							\$ -
28.							\$ -
29.							\$ -
TOTALS:		\$ 1,639,585	\$ 851,613	\$ 350,165	\$ -	\$ -	\$ 2,841,363

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**SCHEDULE H-1 - Ancillary/Therapy Charges for Specialized Care Services (SN/ID, SN/TDC, & NRTP)**

Below, record all Medicaid ancillary/therapy charges for all of the categories reported on Worksheet C of your Medicare cost report. The charges reported below should reflect only the charges for cost incurred by the facility and not any charges billed by an outside vendor for services the outside vendor provided.

\*When this Schedule is required, Total Medicaid Charges equals Total Medicaid Charges reported on Schedule G, Column (e).

\*\*Nursing facility charges include charges for both the nursing facility and, where applicable, the skilled nursing facility unit.

Ancillary / Therapy Line Number Per Medicare Cost Report	Nursing Facility / Skilled Nursing Facility Only**					
	Total Medicaid Charges*	Medicaid Charges SN/ID	Medicaid Charges SN/TDC	Medicaid Charges NRTP-Rehab	Medicaid Charges NRTP- Complex	Other Medicaid Charges
(a)	(b)	(c)	(d)	(e)	(f)	(g)
1.	22.00	\$ 6,680	6,680			\$ -
2.	23.00	\$ -				\$ -
3.	25.00	\$ 411	411			\$ -
4.	26.00	\$ 305	305			\$ -
5.	27.00	\$ 3,352	3,352			\$ -
6.	29.00	\$ 339,417	242,759	96,658		\$ -
7.	30.00	\$ -				\$ -
8.	0.00	\$ -				\$ -
9.	0.00	\$ -				\$ -
10.	0.00	\$ -				\$ -
11.	0.00	\$ -				\$ -
12.	0.00	\$ -				\$ -
13.	0.00	\$ -				\$ -
14.	0.00	\$ -				\$ -
15.	0.00	\$ -				\$ -
16.	0.00	\$ -				\$ -
17.	0.00	\$ -				\$ -
18.	0.00	\$ -				\$ -
19.	0.00	\$ -				\$ -
20.	0.00	\$ -				\$ -
21.	0.00	\$ -				\$ -
22.	0.00	\$ -				\$ -
23.	0.00	\$ -				\$ -
24.	0.00	\$ -				\$ -
25.	0.00	\$ -				\$ -
26.	0.00	\$ -				\$ -
27.	0.00	\$ -				\$ -
28.	TOTALS:	\$ 350,165	\$ 253,507	\$ 96,658	\$ -	\$ -

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**SCHEDULE H-2 - SPECIALIZED CARE DAYS AND EXPENSES**

If you did not provide ID, TDC, and NRTP services, do not complete this schedule.

Please report total specialized service resident days for Medicaid and other payors (cols. (a)-(b)). Report Medicaid specialized care leave days in column (c).

**NOTE: Report the direct routine nursing expenses for specialized care included in your Medicare routine NF/SNF cost centers (cols. (e)-(h)).**

	Resident Days (from Provider's Data)				Specialized Care Included on Medicare W/S A, Line 16, Column 7		Specialized Care Included on Medicare W/S A, Line 18, Column 7	
	Medicaid	Other	Medicaid Leave Days	Total (excl. Leave)	Salary	Other	Salary	Other
	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
1. SN/ID (Infectious Disease)	0			0				
2. SN/TDC (Technology Dependent)	4,121		114	4,121	832,533	11,831		
3. NRTP-Rehab				0				
4. NRTP-Complex				0				
5. NRTP Total	0	0	0	0	\$ -	\$ -	\$ -	\$ -
6. Total Specialized Care	4,121	0	114	4,121	\$ 832,533	\$ 11,831	\$ -	\$ -

SAMPLE

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**SCHEDULE H-3 - SPECIALIZED CARE STATISTICS**

*If you did not provide ID, TDC, and NRTP services, do not complete this schedule.*

**GENERAL SERVICES COST CENTER STATISTICS**

*For each of the general services cost centers on your Medicare cost report, include those statistics attributable to providing SN/ID, SN/TDC, and NRTP services. These statistics will be used to determine the allowable cost of providing SN/ID, SN/TDC, and NRTP services.*

Medicare Cost Report W/S A Line #	Medicare Cost Report Cost Center Category (Column on B-1)	Provider's Data				Total Specialized Care Statistics
		SN/ID Statistics (included in NF/SNF on B-1)	SN/TDC Statistics (included in NF/SNF on B-1)	NRTP-Rehab Statistics (included in NF/SNF on B-1)	NRTP-Complex Statistics (included in NF/SNF on B-1)	
(a)	(b)	(c)	(d)	(e)	(f)	(g)
1. 1.00	Cap Rel Costs - Bldgs & Fixtures		2,467			2,467
2. 2.00	Cap Rel Costs - Movable Equipment		2,467			2,467
3. 5.00	Plant Operation, Maint. & Repairs		2,467			2,467
4. 6.00	Laundry & Linen Service		41,567			41,567
5. 7.00	Housekeeping		2,467			2,467
6. 8.00	Dietary		12,628			12,628
7. 9.00	Nursing Administration		4,912			4,912
8. 10.00	Central Services & Supply		12,120			12,120
9. 11.00	Pharmacy		2,610			2,610
10. 12.00	Medical Records & Library		465,028			465,028
11. 13.00	Social Service		700			700
12. 13.50	Patient Activities		4,171			4,171
13.						0
14.						0
15.						0
16.						0
17.						0
18.						0
19.						0
20.						0
21.						0
22.						0
23.						0
24.						0
25.						0

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**SCHEDULE I-1 - Nursing Facility Medicare / Medicaid Cost Reconciliation**

**Medicaid Cost Adjustments for the Facility's Cost Report**

*Adjustments to allowable cost per Medicare to comply with Medicaid allowable cost for the NURSING FACILITY*

Description (a)	Amount Reported on Medicare Cost Report (b)	Medicare Cost Report Worksheet A			Adjustment Amount (f)	Allowable Cost per Medicaid (g)
		Line (c)	Description (d)	Column (e)		
1.00 Administrator Salary Limit	100,100	4.00	Administrative & General	Salary	(2,578)	\$ 97,522
2.00 Assistant Administrator Salary Limit	56,701	4.00	Administrative & General	Salary	0	\$ 56,701
3.00 Allocation of Medicaid Only Home Office Adjustments						\$ -
3.01 Allocation of Medicaid Only Home Office Adjustments						\$ -
3.02 Allocation of Medicaid Only Home Office Adjustments						\$ -
4.00 Dues	11,977	4.00	Administrative & General	Other	0	\$ 11,977
4.01 Dues						\$ -
5.00 Payroll Taxes (related to salaries on lines 1, 2, 7-15)						\$ -
6.00 Employee Benefits (related to salaries on lines 1, 2, 7-15)						\$ -
7.00 Other Salary Limit:*						\$ -
8.00 Other Salary Limit:*						\$ -
9.00 Other Salary Limit:*						\$ -
10.00 Other Salary Limit:*						\$ -
11.00 Other Salary Limit:*						\$ -
12.00 Other Salary Limit:*						\$ -
13.00 Other Salary Limit:*						\$ -
14.00 Other Salary Limit:*						\$ -
15.00 Other Salary Limit:*						\$ -
<b>TOTALS</b>	\$ 168,778				\$ (2,578)	\$ 166,200

\* Please specify the position of the employee whose salary is being limited on the line provided

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**SCHEDULE I-2 - Home Office Medicare / Medicaid Cost Reconciliation**

**Medicaid Cost Adjustments for the Home Office Cost Statement**

*Adjustments to allowable cost per Medicare to comply with Medicaid allowable cost for the HOME OFFICE*

Description (a)	Amount Reported on Medicare Home Office Cost Statement (b)	Medicare Home Office Cost Statement Schedule B			Adjustment Amount (f)	Allowable Cost per Medicaid (g)
		Line (c)	Description (d)	Column (e)		
1.00 Administrator Salary Limit					\$ -	
2.00 Assistant Administrator Salary Limit					\$ -	
3.00 Dues					\$ -	
3.01 Dues					\$ -	
4.00 Payroll Taxes (related to salaries on Lines 1, 2, & 6-8)					\$ -	
5.00 Employee Benefits (related to salaries on Lines 1, 2, & 6-8)					\$ -	
6.00 Other Salary Limit:*					\$ -	
7.00 Other Salary Limit:*					\$ -	
8.00 Other Salary Limit:*					\$ -	
<b>TOTALS</b>	<b>\$ -</b>				<b>\$ -</b>	<b>\$ -</b>

\* Please specify the position of the employee whose salary is being limited on the line provided



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**SCHEDULE J - Preliminary Direct Care / Care-Related Floor Calculation (Subject to Audit / Desk Review)**

**MEDICARE COST REPORT EXPENSE DATA**

Worksheet A Line Description	Medicare Cost Report Worksheet A Expenses						Adjustments to Medicare Cost		Total Salary Expense	Total "Other" Expense
	Column 1 of W/S A	Column 2 of W/S A	Column 4 of W/S A - Salary Portion Only	Column 4 of W/S A - "Other" Portion Only	Column 6 of W/S A - Salary Portion Only	Column 6 of W/S A - "Other" Portion Only	Salary (from Schedules E-1, F, I-1, H-2)	Other (from Schedules E-1, F, I-1, H-2)		
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(k)
45. SNF - Line 16 of W/S A	2,363,674	28,238				30,000	(832,533)	(28,659)	\$ 1,531,141	\$ 29,579
46. NF - Line 18 of W/S A							0	0	\$ -	\$ -
47. Nursing Administration Line on W/S A	61,027	82,719	171,468	(12,960)			(3,743)	(374)	\$ 228,752	\$ 69,385
48. Central Services & Supply Line on W/S A		139,373					0	0	\$ -	\$ 139,373
49. Pharmacy Line on W/S A		30,010					0	0	\$ -	\$ 30,010
50. Medical Records & Library Line on W/S A		1,093	34,206				0	0	\$ 34,206	\$ 1,093
51. Social Service Line on W/S A	117,653	4,370					0	0	\$ 117,653	\$ 4,370
52. Patient Activities Line on W/S A	40,000						0	0	\$ 40,000	\$ -
53. N/A							0	0	\$ -	\$ -
54. N/A							0	0	\$ -	\$ -
55. N/A							0	0	\$ -	\$ -
56. N/A							0	0	\$ -	\$ -
57. N/A							0	0	\$ -	\$ -
58. N/A							0	0	\$ -	\$ -
59. N/A							0	0	\$ -	\$ -
60. N/A							0	0	\$ -	\$ -

**DIRECT CARE**

61. Direct Care Salaries (Sum of Lines 45 & 46, Column (j), above)	\$ 1,531,141
62. Employee Benefit Allocation (Sum of Lines 45 & 46, Cols. (b) & (d) less Lines 45 & 46, Col. (h) x Line 7, above, plus Schedule F, Lines 6.00 & 6.01)	\$ 215,159
63. Direct Care Contract Nursing (Medicaid Schedule F)	\$ 16,828
64. Total Direct Care Expense	\$ 1,763,128

**CARE-RELATED**

65. Routine Nursing "Other" (Sum of Lines 45 & 46, Column (k), above, less Schedule F, Lines 6.00 & 6.01)	\$ 29,579
66. Raw Food (Medicaid Sched. F after Step-Down Using W/S B-1 Stats)	\$ 208,544
67. Nursing Administration (Medicare W/S A after Step-Down Using W/S B-1 Stats)	\$ 272,213
68. Social Service (Medicare W/S A after Step-Down Using W/S B-1 Stats)	\$ 111,415
69. Patient Activities (Medicare W/S A after Step-Down Using W/S B-1 Stats)	\$ 36,483
70. Care-Related Employee Benefit Allocation (Sum of Social Service, Nursing Admn. & Pat. Act. Lines, Cols. (b) & (d) less Col. (h) x NF %, above)	\$ 49,572
71. Total Care-Related Expense	\$ 707,805

**FLOOR FOR COST REPORT PERIOD**

Rate Period Begin	Rate Period End	Facility Specific Direct Care and Care Related Floor Per Diem from Medicaid Rate Sheet	Calendar Days in Cost Report Period
(a)	(b)	(c)	(d)
72. 1/1/2007	1/31/2007	54.58	31
73. 2/1/2007	2/28/2007	55.06	28
74. 3/1/2007	3/31/2007	56.17	31
75. 4/1/2007	6/30/2007	58.12	91
76. 7/1/2007	9/30/2007	58.75	92
77. 10/1/2007	12/31/2007	57.95	92
78.			0

**FLOOR / EXPENSE COMPARISON**

79. Total Direct Care / Care-Related Expense (Sum of Lines 64 & 71, above)	\$ 2,470,933
80. Total Resident Days (From Schedule B - Stats less Schedule H-2 days)	43,268
81. Total Direct Care / Care-Related Per Diem Cost (Line 79 / Line 80)	\$ 57.11
82. Total Weighted Floor Per Diem for Cost Report Period (From Lines 72-78)	\$ 57.53
83. Floor Per Diem in Excess of Per Diem Cost (Line 82-81, above)	\$ 0.42
84. Cost Report Period Medicaid Days (From Schedule B - Stats)	35,289
85. PRELIMINARY TOTAL DUE MEDICAID (Line 83 x Line 84)*	\$ 14,821

**NOTE: The total amount due Medicaid is subject to change based on DHH desk reviews and audits. After DHH desk review and/or audit and a review of your Medicare cost report, this schedule will be updated and forwarded with the final audit report for you to remit payment. DO NOT REMIT PAYMENT WITH YOUR SUBMITTED COST REPORT!**

**LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS  
BUREAU OF HEALTH SERVICES FINANCING  
Nursing Facility Medicaid Cost Report**

PROVIDER: Facility B

5555

FROM: 1/1/2007

TO: 12/31/2007

**SCHEDULE K - Certification Statement by Preparer and Owner, Officer, or Administrator of Facility**

I, \_\_\_\_\_, \_\_\_\_\_  
(Name) (Administrative Title)

of Facility B  
(Name of Facility)

Baton Rouge, LA do certify that I have examined the  
(City) (State)

attached report for the cost report period beginning 1/1/2007 and ending 12/31/2007 and to the best of my knowledge and belief, it is a true and correct statement of the information required.

\_\_\_\_\_  
Signature of Authorized Representative of Facility Date

\_\_\_\_\_  
Title

CERTIFICATION BY ACCOUNTANT

I have prepared the NF Cost Report of Facility B for the cost  
(Name of Facility)  
report period beginning 1/1/2007 and ending 12/31/2007 and in my

opinion, except for the comments stated below, all information contained in the NF Medicaid Cost Report is fairly stated and in accordance with the instructions furnished by Louisiana Department of Health and Hospitals Administration and the Principles of Reasonable Cost as set forth in the Medicare Provider Reimbursement Manual (HIM-15).

Total Inpatient Nursing Days:	47,389	Floor Calculation - Due to State:	\$ 14,821
Specific Cost Detail for Rate-Setting:	\$ 652,186	Total Adjs on Schedule I-1 NF Recon:	\$ (2,578)

Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Preparer Date

\_\_\_\_\_  
Name of Preparer

**LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS  
BUREAU OF HEALTH SERVICES FINANCING  
Nursing Facility Medicaid Cost Report**

PROVIDER: Facility B

5555

FROM: 1/1/2007

TO: 12/31/2007

**SCHEDULE L - COST REPORT CHECKLIST (REQUIRED ITEMS)**

NAME OF CONTACT PERSON: Glen Dorsey PHONE: (225) 225-2252 EMAIL: gdorsey@anytown.com

**NOTE: Cost Report files must be submitted electronically to Myers and Stauffer using e-mail ([LANF@mslc.com](mailto:LANF@mslc.com)). Name the cost report file as noted in the examples at the bottom of this form. All other items should be mailed or scanned and e-mailed to Myers and Stauffer. If mailing items, please submit ALL ITEMS numbered and in numerical order. If sending scanned copies of documentation, use the name format shown in the examples at the bottom of this form.**

**Required Items (Must be submitted with your filing)**

	Yes	No	N/A*	Prev. Sub- mitted
1. Signed and dated Certification Page of the Louisiana Medicaid NF Cost Report	[ ]	[ ]		
2. Signed and dated Certification Page of the Medicare Cost Report (W/S S, Parts I & II)	[ ]	[ ]		
3. Working trial balance used to prepare the Medicare Cost Report <i>(Must include totals by cost center that agree to columns 1 and 2 on W/S A, W/S C, W/S G, W/S G-1, W/S G-2, &amp; W/S G-3)</i>	[ ]	[ ]		
4. Supporting documentation for Worksheet A-6, A-8 and A-8-1 reclassifications and adjustments	[ ]	[ ]		
5. Signed and completed provider cost report reimbursement questionnaire (CMS 339)	[ ]	[ ]		
6. A copy of your nursing facility's Medicare PS&R for the cost report period	[ ]	[ ]		
7. A copy of your annual audit, compilation or review from independent accountant	[ ]	[ ]	[ ]	
8. A copy of the straight-line depreciation schedule. Amount must agree to the Medicare cost report.	[ ]	[ ]		
9. Copy of all lease and loan agreements and any amortization schedules <i>(if applicable)</i>	[ ]	[ ]		[ ]
10. Copy of all Form 941s or state unemployment reports for the cost report period	[ ]	[ ]		
11. Copy of the facility license for the cost report period	[ ]	[ ]		
12. Copy of the management company contract and, if a related party, management company cost allocation schedule. Name of management company: <span style="background-color: yellow; display: inline-block; width: 150px; height: 1em;"></span>	[ ]	[ ]		
13. E-mail electronic data files for the Medicare and Medicaid cost reports to <a href="mailto:LANF@mslc.com">LANF@mslc.com</a>	[ ]	[ ]		
14. Supporting documentation for Administrator and Assistant Administrators' salary reported on Schedule F (Submit W-2 with reconciliation to the accrual basis salaries reported on Medicare Worksheet A)	[ ]	[ ]		
15. Supporting documentation for property taxes (Submit property tax notice and related canceled checks).	[ ]	[ ]		
16. Supporting documentation for property insurance (Submit all invoices/premium notices for all policy periods within the cost report period. Include canceled checks, allocation of invoices between property and other types of insurance, allocation of insurance to facilities in a related group, if applicable, and any other schedule necessary to reconcile amounts reported on Schedule F)	[ ]	[ ]		

**NOTE: A signed and completed Medicare Home Office cost statement and Louisiana Medicaid NF cost report and all required attachments for both cost reports should be completed and submitted for all home offices. Only one copy of the home office cost reports and related attachments is required.**

\*N/A means this information does not exist for this facility

**File Naming Examples:**

- Medicaid Cost Report File:** *NH 55555 ABC Management Co, Inc. - DEF Nursing Home As filed cost report 20081231.pdf*
- If You Have One Attachment File:** *NH 55555 ABC Management Co, Inc. - DEF Nursing Home CR attachments 20081231.pdf*
- If You Have Multiple Attachment Files:** *NH 55555 ABC Management Co, Inc. - DEF Nursing Home CR attachments 20081231 WTB-1.pdf (or .xls)*  
*NH 55555 ABC Management Co, Inc. - DEF Nursing Home CR attachments 20081231 PS&R-2.pdf*  
*etc...*

**LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS  
BUREAU OF HEALTH SERVICES FINANCING  
Nursing Facility Medicaid Cost Report**

PROVIDER: Facility B 5555  
 FROM: 1/1/2007 TO: 12/31/2007

Validation Edits			
Comparison #1	Comparison #2	Potential Errors	
Total NAT <span style="float: right;">\$ 4,867</span> <i>(Sched. E-1 - Line 20)</i>	Total NAT Posted <span style="float: right;">\$ (4,867)</span> <i>(Sched. E-1 - Line 68)</i>	\$	-
Specialized Care Offered? <span style="float: right;">TRUE</span> <i>(Schedule A)</i>	Specialized Care Schedules Completed? <span style="float: right;">TRUE</span> <i>(Schedules H-1, H-2, &amp; H-3)</i>		
Allowable Leave / Bed-Holds <span style="float: right;">961</span> <i>(Schedule B)</i>	Spec. Care Leave Days <span style="float: right;">114</span> <i>(Sched. B - Stats, Line 5a)</i>		-
Maximum Calculated Bed Days <span style="float: right;">52,925</span> <i>(Schedule B)</i>	Actual Resident Days <span style="float: right;">48,350</span> <i>(Schedule B, Column j)</i>		-
Specific Cost Rate-Setting Total <span style="float: right;">\$ 652,186</span> <i>(Schedule F-1)</i>	Specific Cost Rate-Setting Posted <span style="float: right;">\$ (652,186)</span> <i>(Calculated from Schedule F-1)</i>		
Medicaid Ancillary Charges <span style="float: right;">\$ 350,165</span> <i>(Sched. G, Line 20, Col. (e))</i>	Other Medicaid Charges <span style="float: right;">\$ -</span> <i>(Sched. H-1, Col. (g), Line 18)</i>		
Specialized Care Routine Cost <span style="float: right;">\$ 844,364</span> <i>(Schedule H-2)</i>	Total NF/SNF Routine Cost <span style="float: right;">\$ 2,421,912</span> <i>(Schedule J - Floor Calculation)</i>		
NRTP Days on Schedule B <span style="float: right;">0</span>	NRTP Days on Schedule H-2 <span style="float: right;">0</span>		0
Medicaid Only Adjustments - NF <span style="float: right;">\$ (2,578)</span> <i>(Schedule I-1 - NF Recon)</i>	Medicaid Only Adjs. NF - Posted <span style="float: right;">\$ (2,578)</span> <i>(Calculated from Schedule I-1 - NF Recon)</i>	\$	-
Total DHH Adjustments Posted <span style="float: right;">0.00</span>	Total DHH Adjustments Entered <span style="float: right;">0.00</span>	\$	-

\*\*Amounts in Difference column should be zero and messages should be cleared.

# **APPENDIX IV**

## **CASE MIX CROSS- WALKS**

WARNING: While the Medicare cost report may allow more than one option for classifying costs, Medicaid will only recognize costs in a rate and floor component based on the case mix cross-walk shown below. If a facility chooses to classify cost on the Medicare cost report in a manner that excludes that cost from their direct care or care-related rate component and floor, then the cost will forever be excluded from the direct care and care-related rate and floor, unless adjusted at audit or desk review. If there are any questions related to the cross-walk, please contact DHH or Myers and Stauffer for clarification.

**Medicare 2540-96 Cost Center Crosswalk to Louisiana Case Mix Rate and Direct Care / Care-Related Components**

Cost Center Category	CMS Form 2540-96 Cost Center	Rate / Floor Component					
		Fair Rental Value	Admin. & Operating	Direct Care	Care-Related	Pass-Through	Excluded
General Service Cost Centers <sup>1</sup>	Capital Bldg. & Fixtures / Capital Moveable Equip. <sup>2</sup>	X					
	Employee Benefits - allocated based on salaries		X	X	X		X <sup>3</sup>
	Administrative & General		X				
	Maint. & Repair		X				
	Operation of Plant		X				
	Laundry		X				
	Housekeeping		X				
	Dietary		X				
	Nursing Admin.					X	
	Central Service		X				
	Pharmacy		X <sup>4</sup>				
	Medical Records		X				
Social Service					X		
Activities					X		
Routine Service Cost Centers	Skilled Nursing Facility and Nursing Facility - Salary			X			
	Skilled Nursing Facility and Nursing Facility "Other" Cost Other Routine				X		X
Ancillary Service Cost Centers	Laboratory (Direct Cost)						X
	Respiratory Therapy (Direct Cost)						X
	Physical Therapy (Direct Cost)						X
	Occupational Therapy (Direct Cost)						X
	Speech Pathology (Direct Cost)						X
	Med Supplies Charged (Direct Cost)						X
	Drugs Charged (Indirect & Direct Cost)						X
	Radiology (Direct Cost)						X
	Other Reimbursable Ancillary (Direct Cost)						X
Other Non-Reimbursable Ancillary (Direct Cost)						X	
Other Outpatient Services	Clinic						X
Non-Reimbursable Cost Centers	Apartments / Residential						X
	Gift, Flower, Coffee & Canteen						X
	Other Non-Reimbursable						X

**Medicaid Cost Report Cross-Walk to Louisiana Case-Mix Rate and Direct Care / Care-Related Floor Components**

Cost Center Category	From Medicaid Schedule F - Specific Cost	Rate / Floor Component					
		Fair Rental Value	Admin. & Operating	Direct Care	Care-Related	Pass-Through	Excluded
Medicaid - Specific Cost Centers <sup>1</sup>	Property Tax & Insurance					X	
	Raw Food				X		
	Provider Fees <sup>5</sup>					X <sup>5</sup>	X <sup>5</sup>
	Direct Patient Care Contract Nursing Cost			X			
	Employee Benefits Directly Allocated to Nursing Cost Centers			X			

<sup>1</sup> Includes all direct cost excluding the portion allocated either directly or indirectly to non-reimbursable cost centers and other long-term care cost centers.

<sup>2</sup> Fair Rental Value calculation replaces the cost in these cost centers. The capital cost is not used in the development of the Fair Rental Value.

<sup>3</sup> The only employee benefits excluded are those that are allocated directly or indirectly to non-reimbursable cost centers and other routine service cost centers; those allocated directly to ancillary cost centers; and those allocated to pharmacy salaries in ancillary cost centers.

<sup>4</sup> Excludes pharmacy overhead allocation to any ancillary cost centers.

<sup>5</sup> For rate-setting purposes provider fee expense is removed from the provider's cost (A&G) and a flat add-on amount is added to the rate.

**Note:** Please note the following issues that may result in lower Direct Care / Care-Related costs included in the floor and rates:

- (a) Missing Patient Activities cost center on Medicare cost report W/S A.
- (b) Direct cost of routine (non-legend) drugs NOT properly reclassified on W/S A-6 to nursing cost centers from the Pharmacy cost center.
- (c) Direct cost of routine medical supplies NOT properly reclassified on W/S A-6 to nursing cost centers from the Central Service cost center.

## Louisiana Rate Setting Summary Allocation Report

**Provider Number:** Facility B  
**Provider Name:** 55555

**Period Begin:** 1/1/2007  
**Period End:** 12/31/2007

Section: 1	Description	Capital - Bldg. & Fixtures	Capital - Moveable Equipment	Employee Benefits Direct Care <sup>(1)</sup>	Employee Benefits Care Related <sup>(1)</sup>	Employee Benefits Admin <sup>(1)</sup>	Employee Benefits Other <sup>(1)</sup>	Admin. & General	Maint. & Repair	Operation of Plant	Laundry & Linen	House-Keeping
	Skilled Nursing Facility	242,432 <sup>(D)</sup>	45,702 <sup>(D)</sup>	215,159 <sup>(A)</sup>	49,572 <sup>(B)</sup>	50,931 <sup>(C)</sup>		331,565 <sup>(C)</sup>	303,106 <sup>(C)</sup>	0 <sup>(C)</sup>	32,595 <sup>(C)</sup>	153,740 <sup>(C)</sup>
	Other Routine Service Cost	25,073	4,726				130,284 <sup>(D)</sup>	104,393 <sup>(D)</sup>	28,869 <sup>(D)</sup>	0 <sup>(D)</sup>	3,104 <sup>(D)</sup>	14,642 <sup>(D)</sup>
	Laboratory	40	7			104 <sup>(C)</sup>		1,103 <sup>(C)</sup>	12 <sup>(C)</sup>	0 <sup>(C)</sup>	0 <sup>(C)</sup>	6 <sup>(C)</sup>
	Physical Therapy	2,359	445			1,494		16,544	2,478	0	0	1,279
	Occupational Therapy	2,160	406			1,004		10,978	2,415	0	0	1,247
	Speech Pathology	716	135			496		5,254	744	0	0	384
	Med Supplies Charged	6,300	1,188			1,934		26,267	7,253	0	0	3,744
	Drugs Charged to Patients	354	67			818		11,493	54	0	0	28
	Other Reimbursable Ancillary	94	17			206		3,185	9	0	0	5
	Other Non-Reimbursable	0	0				0 <sup>(D)</sup>	0 <sup>(D)</sup>	0 <sup>(D)</sup>	0 <sup>(D)</sup>	0 <sup>(D)</sup>	0 <sup>(D)</sup>
	<b>Totals</b>	<b>279,528</b>	<b>52,693</b>	<b>215,159</b>	<b>49,572</b>	<b>56,987</b>	<b>130,284</b>	<b>510,782</b>	<b>344,940</b>	<b>0</b>	<b>35,699</b>	<b>175,075</b>

**1,547,969 (A) Direct Care**  
**29,579 (B) Care Related**

Section: 2	Description	Dietary	Nursing Admin.	Central Service	Pharmacy	Medical Records	Social Service	Activities	Prop. Taxes & Insurance	Food	Provider Fees	Direct Costs	Totals
	Skilled Nursing Facility	181,472 <sup>(C)</sup>	272,213 <sup>(B)</sup>	53,488 <sup>(C)</sup>	27,400 <sup>(C)</sup>	21,044 <sup>(C)</sup>	111,415 <sup>(B)</sup>	36,483 <sup>(B)</sup>	47,747 <sup>(E)</sup>	208,544 <sup>(B)</sup>	228,431 <sup>(F)</sup>	1,577,548 <sup>(D)</sup>	4,190,587
	Other Routine Service Cost	17,285 <sup>(D)</sup>	25,924 <sup>(D)</sup>	5,094 <sup>(D)</sup>	2,610 <sup>(D)</sup>	2,005 <sup>(D)</sup>	10,608 <sup>(D)</sup>	3,517 <sup>(D)</sup>	4,938 <sup>(D)</sup>	19,863 <sup>(D)</sup>	71,920	844,364 <sup>(D)</sup>	1,319,219
	Laboratory	0 <sup>(C)</sup>	0 <sup>(B)</sup>	0 <sup>(C)</sup>	0	325 <sup>(C)</sup>	0 <sup>(B)</sup>	0 <sup>(B)</sup>	7 <sup>(E)</sup>	0 <sup>(B)</sup>	759	11,570	13,933
	Physical Therapy	0	0	0	0	3,919	0	0	464	0	11,397	168,681	209,060
	Occupational Therapy	0	0	0	0	2,543	0	0	426	0	7,563	109,987	138,729
	Speech Pathology	0	0	0	0	1,410	0	0	141	0	3,619	53,484	66,383
	Med Supplies Charged	0	0	80,791	0	2,395	0	0	1,242	0	18,095	182,722	331,931
	Drugs Charged to Patients	0	0	0	0	1,414	0	0	70	0	7,918	123,029	145,245
	Other Reimbursable Ancillary	0	0	0	0	244	0	0	19	0	2,195	34,282	40,256
	Other Non-Reimbursable	0 <sup>(D)</sup>	0 <sup>(D)</sup>	0 <sup>(D)</sup>	0	0 <sup>(D)</sup>	0 <sup>(D)</sup>	0 <sup>(D)</sup>	0 <sup>(D)</sup>	0 <sup>(D)</sup>	0	0	0
	<b>Totals</b>	<b>198,757</b>	<b>298,137</b>	<b>139,373</b>	<b>30,010</b>	<b>35,299</b>	<b>122,023</b>	<b>40,000</b>	<b>55,054</b>	<b>228,407</b>	<b>351,897</b>	<b>3,105,667</b>	<b>6,455,343</b>

<sup>(1)</sup> allocated based on salaries  
<sup>(2)</sup> allocated between salary and other expenses in the Routine Service cost centers

**TOTALS**

$\Sigma$  (A) = 1,763,128 = Direct Care Costs  
 $\Sigma$  (B) = 707,806 = Care Related Costs  
 $\Sigma$  (C) = 1,348,920 = Administrative and Operating Costs  
 $\Sigma$  (D) = 2,233,476 = Excluded Costs (Specialized Care / Non-Reimbursable / Ancillary Direct)  
 $\Sigma$  (E) = 50,116 = Property Taxes plus Insurance  
 $\Sigma$  (F) = 351,897 = Provider Fees (Pay provider tax rate)  
6,455,343

# **APPENDIX V**

## **FAIR RENTAL VALUE RE-AGE REQUEST FORM**

**Louisiana Department of Health and Hospitals  
Nursing Facility Case-Mix Fair Rental Value Re-Age Request**

Provider Name:

Medicaid Provider Number:

Date of Request:

**Note #1:** Per §1305.D.3.a.iv of the Louisiana Case-Mix rule, in order to change the weighted age of a facility, the cost of the renovation/addition must at least equal \$500 per bed.

**Note #2:** All proceeds from insurance or other federal assistance payments (FEMA, etc.) must be offset against the capitalized cost of all renovations, additions, and replacements.

**Additions**

Description	Licensed Nursing Facility Beds Added	Total Addition Cost Capitalized		Square Feet Added		Period of Construction		Date Placed in Service
		Nursing Facility	Non-Nursing Facility	Nursing Facility	Non-Nursing Facility	From	To	

**Renovations**

Description	Total Renovation Cost Capitalized		Square Feet Change (Removed Square Feet or Reallocated Existing Square Feet)		Period of Construction		Date Placed in Service
	Nursing Facility	Non-Nursing Facility	Nursing Facility	Non-Nursing Facility	From	To	

**Replacements**

Description	Licensed Nursing Facility Beds Replaced	Total Cost Capitalized		Square Feet Change (Difference in New Location vs. Old Location of Beds)		Period of Construction		Date Placed in Service
		Nursing Facility	Non-Nursing Facility	Nursing Facility	Non-Nursing Facility	From	To	

**Documentation Checklist**

- 1. Attached copy of revised bed license  Yes  N/A
- 2. Attached depreciation schedule showing date placed in service and capitalized cost  Yes  N/A
- 3. Attached copies of revised floor plans with changes to square footage indicated  Yes  N/A
- 4. Documentation of all insurance proceeds or government assistance payments (FEMA, etc.) received.  Yes  N/A

**Due Dates**

Rate Effective Date	Due Date
January 1	December 31
April 1	March 31
July 1	June 30
October 1	September 30

**Send this signed form and all supporting documentation to:**

Attn: Louisiana NF  
Myers and Stauffer, LC  
11440 Tomahawk Creek Parkway  
Leawood, KS 66211  
Phone: 1-800-374-6858 ext. 1257  
Fax: (913) 234-1104  
e-mail: lanf@mslc.com

\_\_\_\_\_  
Administrator / Management Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

# **APPENDIX VI**

## **CAPITAL RE-AGE MEMO**

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**LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS  
RATE AND AUDIT  
NURSING FACILITY MEMORANDUM**

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**TO:** NURSING HOME ADMINISTRATORS  
**FROM:** KENT BORDELON, DIRECTOR OF RATE AND AUDIT  
**SUBJECT:** LOUISIANA MEDICAID NURSING FACILITY CASE-MIX CAPITAL RE-AGE REQUESTS  
**DATE:** 1/10/2008  
**CC:** BOB HICKS, MYERS AND STAUFFER LC

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As published in the Louisiana Register on December 20, 2006, nursing facilities paid under the case-mix reimbursement system may now submit capital re-age requests on a quarterly basis. All qualifying re-age requests received by the end of each calendar quarter will be incorporated into the next quarter's case-mix rate.

A capital re-age must meet the requirements stated in §1305.D.3.b.v of the Louisiana Register dated December 20, 2006. Below is a list of the major requirements and clarifications.

1. Major renovations/improvements must be equal to or exceed \$500 per licensed bed.
2. A major renovation/improvement must relate to an actual renovation/improvement and not the normal everyday purchases of various unrelated capitalized assets across the facility. A major renovation/improvement is a continuous project with expenses related to the specific renovation/improvement of a specific nursing-facility area or nursing-facility asset.
3. The \$500 per bed minimum must be met on each renovation/improvement project to be included in a re-age calculation.
4. The renovations/improvements must be related to nursing facility areas only. Areas used for other purposes such as assisted living or apartments cannot be included in meeting the \$500 minimum.
5. The renovations/improvements must have been placed into service within the previous 24 months prior to re-aging. Older projects will not be recognized.
6. For cost report purposes, costs must be capitalized in accordance with the Medicare provider reimbursement manual 15-1, §133 to be considered in a re-aging. For casualty losses, the Medicare provider reimbursement manual 15-1, §133 explains that Medicare recognizes the following:
  - a. The decrease in the asset's net book value after the casualty loss.
  - b. All insurance proceeds and government gifts/grants.

- c. Additional capitalized costs for the replacement or renovation of the impaired asset.

For fair rental value re-aging, the above items are also recognized to the extent that they increase net book value.

**Facility A Fair Rental Value Re-Age Example:**

Facility A renovations completed and capitalized after casualty loss:	\$2,500,000
Facility A insurance proceeds / government grant money:	<u>\$1,500,000</u>
<b>Total amount recognized in the fair rental value re-age:</b>	<b><u><u>\$1,000,000</u></u></b>

**Facility A Medicare Provider Reimbursement Manual Example:**

Facility A net book value prior to casualty loss:	\$4,000,000
Less facility A net book value after casualty loss:	\$2,000,000
Less facility A insurance proceeds / government grant money:	<u>\$1,500,000</u>
Net loss\gain capitalized over the life of the new asset:	\$ 500,000
Plus facility A renovations completed and capitalized after casualty loss:	<u>\$2,500,000</u>
Increase in facility A book value recognized by Medicare:	\$3,000,000
Plus facility A book value after casualty loss and prior to renovations:	<u>\$2,000,000</u>
Facility A net book value after casualty loss and renovations:	<u>\$5,000,000</u>
Less facility A net book value prior to casualty loss:	<u>\$4,000,000</u>
<b>Increase in facility A net book value</b>	<b><u><u>\$1,000,000</u></u></b>

To claim a capital re-age, please submit the attached form with all supporting documentation by the end of each calendar quarter. The attached form will be available in an electronic format on the Department of Health and Hospitals, Rate and Audit web-site.

If you have any questions concerning this memorandum, please contact Bob Hicks at 1-800-374-6858 x1249 or e-mail at bhicks@mslc.com.

**APPENDIX VII**

**SAMPLE RATE**

**SHEET**

**LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS  
OCTOBER 1, 2009 SCHEDULE OF REIMBURSEMENT RATE**

<b>Facility B</b>	Prepared Date . . . . .	01/15/2009	
555 West Main	Rate Effective Date . . . . .	10/01/2009	
Baton Rouge, LA 77777	12/31/2009 Inflation Factor . . . . .	6.8581%	
Provider Number . . . . .	55555	Current Licensed Beds . . . . .	145
Base Year Cost Report Period . . . . .	01/01/2007 To 12/31/2007	Annual Bed Days Available . . . . .	52925
Bed Days Available per Base Year Cost Report Period . . . . .	52,925	Occupancy Percentage per Base	
Resident Days per Base Year Cost Report Period . . . . .	47,389	Year Cost Report Period . . . . .	89.54%
Specialized Service Days (TDC, ID, NRTP) . . . . .	4,121	Annual Resident Days per Base	
Facility Cost Report Period Case-mix Index . . . . .	1.1227	Year Occupancy Percentage . . . . .	47,389
<b>07/01/2009</b> Facility-wide Average Case-mix Index . . . . .	1.1858	(cost report period is the base year cost report period)	

**CALCULATION FOR FAIR RENTAL VALUE PER DIEM**

Weighted Age of Facility (maximum age of 30 years)	20
Total Square Feet	37,500
Total Square Feet per Bed ( 37,500 / 145 )	259
Allowable Square Feet per bed (min of 300 sq ft per bed and max of 450 sq ft per bed)	300
Allowable Square Feet per (current lic beds * allowable square feet per bed)	43,500
Gross Facility Value ([allow. square ft * \$164.40] + [current lic beds * \$6,132.00])	\$8,040,540
Depreciation Rate (weighted age * 1.25%)	25.00%
Depreciated Facility Value (land value of \$14.96 per sq ft is not depreciated)	\$6,193,095
Rental Rate	9.25%
Annual Fair Rental Value	\$572,861
Divided by Greater of Total Patient Days or 70% of Total Bed Days	47,389
Fair Rental Value Per Diem	\$12.09

**CALCULATION OF FACILITY SPECIFIC DIRECT CARE AND CARE RELATED PRICE AND FLOOR**

	WAGE INCREASE	DIRECT CARE	CARE RELATED	TOTAL
Base Year Per Diem Cost - C/R Period Ending 12/31/2007		\$44.30	\$17.79	\$62.09
Divided by the Facility Cost Report Period Case-mix Index		1.1227	N/A	
Facility Neutralized Direct Care Cost and Care Related Cost		\$39.46	\$17.79	\$57.25
Percentage of Total		73.59%	26.41%	100%
<b>Price:</b>				
Distribution of Statewide Direct Care and Care Related Price	\$ 1.30	\$49.95	\$17.92	\$69.17
Times the Facility-wide Average Case-mix Index	1.1858	1.1858	N/A	
Facility Specific Direct Care and Care Related Price	\$ 1.54	\$59.23	\$17.92	\$78.69
<b>Floor:</b>				
Distribution of Statewide Direct Care and Care Related Floor	\$ 1.22	\$42.68	\$15.32	\$59.22
Times the Facility-wide Average Case-mix Index	1.1858	1.1858	N/A	
Facility Specific Direct Care and Care Related Floor	\$ 1.45	\$50.61	\$15.32	\$67.38

**CALCULATION OF REIMBURSEMENT RATE**

Administrative and Operating Rate	\$ 40.32
Facility Specific Direct Care and Care Related Rate	\$ 78.69
Capital Rate	\$ 12.09
Pass-Through Rate:	
Property Tax and Property Insurance (Inflated from base year to 12/31/2009)	\$ 1.25
Provider Fee	\$ 8.02
<b>Medicaid Reimbursement Rate Effective October 1, 2009</b>	<b>\$140.37</b>

**LEAVE OF ABSENCE RATES**

Occupancy % (LA Inventory of NH Bed Utilization Report)	89.54%
Hospital Leave of Absence Per Diem	\$ 21.26
Home Leave of Absence Per Diem Rate	\$ 21.26

**APPENDIX VIII**

**BED BUY BACK**

**SAMPLE**

**CALCULATION**

## Bed Buy-Back Calculation

### Medicaid Incentive Payment

<b>Seller Data</b>		<b>Closed Facility (Seller)</b>			
1	Beds	130			
2	Date of Legal Transfer of Ownership	10/1/2009			
3	Date of Closure of Purchased Facility	11/1/2009			
<b>Buyer Data</b>		<b>Buyer #1:</b>	<b>Buyer #2:</b>	<b>Buyer #3:</b>	<b>TOTALS:</b>
4	Rebase CR Beginning	1/1/2007	7/1/2006	1/1/2007	
5	Rebase CR Ending	12/31/2007	6/30/2007	10/31/2007	
6	Medicaid Days During Rebase CR Period	24,000	11,000	15,000	50,000
7	Beds (at rebase)	150	100	120	370
8	Occupancy % at 10/01/2009	65.00%	60.00%	70.00%	65.41%
9	Buyer's Percentage Share of the Purchased Facility	60%	30%	10%	100%
10	Total residents transferred from Closed Facility to Buyer and still in Buyer facility at 12/30/2009	50	25	30	105
11	Medicaid residents transferred from Closed Facility to Buyer and still in Buyer facility at 12/30/2009	25	15	20	60
<b>Increased Occupancy</b>					
12	Number of Beds Occupied at 10/01/2009 (Line 7 x Line 8)	98	60	84	242
13	Number of Additional Beds Occupied at 12/30/2009 (Line 10)	50	25	30	105
14	Total Number of Occupied Beds Used in Calculation (Line 12 + Line 13)	148	85	114	347
15	Occupancy % To Use in Calculation (Line 14/Line 7)	98.67%	85.00%	95.00%	93.78%
16	Increased Occupancy % (Line 15 - Line 8)	33.67%	25.00%	25.00%	28.37%
<b>Capital Amount per Rule</b>					
17	Base Capital Amount Per Table (from Rule and updated for RS Means)				\$ 480,845
18	Percentage Paid (By Rule based on Occupancy Increase)				100%
19	Total Medicaid Incentive Payment (Line 17 x Line 18)				\$ 480,845
20	Buyer's Percentage Share (Line 9)	60%	30%	10%	100%
21	Total Medicaid Incentive Payment per Buyer (Line 19 x Line 20)	\$ 288,507	\$ 144,254	\$ 48,085	\$ 480,846
<b>Annual Payment</b>					
22	Additional Medicaid Days, annualized (Line 11 x 365 days)	9,125	5,475	7,300	21,900
23	Buyer's Medicaid Days from Rebase, annualized (Line 6 annualized)	24,000	11,000	18,010	53,010
24	Total Annualized Medicaid Days after Purchase (Line 22 + Line 23)	33,125	16,475	25,310	74,910
25	Per Diem Payment Add-On Beginning 01/01/2010 Until Next Rebase (Line 21/Line 24)	\$ 8.71	\$ 8.76	\$ 1.90	\$ 6.42

### Retroactive Restatement of FRV and Property Tax/Insurance Rates

	<b>Buyer #1:</b>	<b>Buyer #2:</b>	<b>Buyer #3:</b>	<b>TOTALS:</b>	
26	Total Annualized Resident Days Used at Rebase for FRV and Property Tax/Insurance PRIOR to Application of the 70% Minimum Occupancy	35,500	20,000	30,000	85,500
27	Total Additional Days from Transferred Residents for FRV (Line 10 x 365)	18,250	9,125	10,950	38,325
28	Revised Total FRV Resident Days (Line 26 + Line 27)	53,750	29,125	40,950	123,825
29	70% Minimum Occupancy (Line 7 x 70% x 365 days)	38,325	25,550	30,660	94,535
30	Revised Resident Days Used for FRV (Greater of Line 28 or Line 29)	53,750	29,125	40,950	123,825
31	Current Fair Rental Value Total (from Rebase Calculation)	\$ 600,000	\$ 400,000	\$ 500,000	\$ 1,500,000
32	Revised Fair Rental Value Per Diem (Restated Back to 12/01/2009) (Line 31/Line 30)	\$ 11.16	\$ 13.73	\$ 12.21	\$ 12.11
33	Total Additional Days from Transferred Residents for Property Tax/Insurance (Line 10 x Cost Report Period Days)	18,250	9,125	9,120	36,495
34	Revised Total Property Tax/Insurance Resident Days (Line 26 + Line 33)	53,750	29,125	39,120	121,995
35	Total Property Tax and Insurance Used in Rebase	\$ 55,000	\$ 40,000	\$ 50,000	\$ 145,000
36	Revised Property Tax and Insurance Per Diem (Restated Back to 12/01/2009) (Line 35/Line 34)	\$ 1.02	\$ 1.37	\$ 1.28	\$ 1.19

### Next Rebase Calculations

37	Next Rebase Date	7/1/2010			
	<b>Buyer #1:</b>	<b>Buyer #2:</b>	<b>Buyer #3:</b>	<b>TOTALS:</b>	
38	7/1/2010 Rebase Cost Report Period Beginning	1/1/2008	1/1/2008	11/1/2007	
39	7/1/2010 Rebase Cost Report Period Ending	12/31/2008	6/30/2008	10/31/2008	
40	Percentage of Period Before 11/01/2009 (Closure Date of Purchased Facility)	100.00%	100.00%	100.00%	
41	Total Resident Days to Add to FRV Calculation PRIOR to Minimum Occupancy at 07/01/2010 Rebase (Line 27 x Line 40)	18,250	9,125	10,950	
42	Total Resident Days to Add to Property Tax and Insurance Per Diem Calculation at 07/01/2010 Rebase (Line 10 x Cost Report Period Days)	18,250	4,550	10,950	
43	Total Additional Annualized Medicaid Days from Transferred Residents (Line 22 x Line 40)	9,125	5,475	7,300	
44	Total Annualized Medicaid Days from 07/01/2010 Rebase Cost Report	24,000	13,000	16,000	
45	Total Medicaid Days Used in Incentive Calculation at 07/01/2010 Rebase	33,125	18,475	23,300	
46	Incentive Payment (Line 21)	\$ 288,507	\$ 144,254	\$ 48,085	\$ 480,846
47	Revised Incentive Per Diem at 7/1/2010 Rebase (Line 46/Line 45)	\$ 8.71	\$ 7.81	\$ 2.06	

Incentive Payment Ends on 12/31/2014

# **APPENDIX IX**

## **PRIVATE ROOM CONVERSION SAMPLE CALCULATION**

**Louisiana Department of Health and Hospitals  
Private Room Conversion Calculations**

**Data Prior to Private Room Conversions**

1 Base Year Cost Report FYB	7/1/2006
2 Base Year Cost Report FYE	6/30/2007
3 Base Year Cost Report Total Resident Days	22,291
4 Base Year Bed Days Available	33,215
5 Current Licensed Beds prior to Conversion	91
6 Total Square Footage prior to Conversion	26,912
7 Square Feet per Bed prior to Conversion (line 6 / line 5)	296
8 Allowable Square Feet per Bed prior to Conversion (Max of 450, Min of 300)	300
9 Total Allowable Square Feet prior to Conversion (line 8 x line 5)	27,300
10 Annualized Resident Days Using Base Year Occupancy % (line 3 / line 4 x (line 5 x 365))	22,291
11 70% of Bed Days Available (70% x line 5 x 365)	23,251
12 Greater of Annualized Resident Days or 70% Minimum Occupancy after Conversion (Greater of lines 10 and 11)	23,251
13 Gross Facility Value	\$ 4,714,346
14 Allowed Weighted Age of Facility	24
15 Depreciation % (1.25% per year)	30%
16 Depreciated Facility Value	\$ 3,414,538
17 Rental Fee	9.25%
18 Annual FRV	\$ 315,845
19 FRV Per Diem (line 18 / line 12)	\$ 13.58

**General Private Room Conversion Information**

20 Date of Conversions	10/1/2009
21 Date Facility Met All Qualifying Criteria in Section 1310.B.1	11/1/2009
22 Number of Licensed Beds Surrendered	10
23 Number of Private Rooms Converted (must equal line 22)	10
24 Number of Licensed Beds After Conversion (line 5 - line 22)	81

**Concurrent Change in Square Footage**

25 Was a New Building Opened Concurrent with the Private Room Conversion?	NO
26 Square Footage Prior to Change (line 6)	26,912
27 Change in Square Footage	-
28 Revised Square Footage (line 26 + line 27)	26,912
29 Square Feet per Bed (Prior to Conversion) (line 28 / line 5)	296
30 Allowable Square Feet per Bed (Prior to Conversion) (Max of 450, Min of 300)	300
31 Total Allowable Square Feet (Prior to Conversion) (line 30 x line 5)	27,300

**Initial Private Room Conversion FRV Per Diem Calculation**

32 Total Square Footage (line 28)	26,912
33 Square Feet per Bed After Conversion (line 32 / line 24)	332
34 Allowable Square Feet per Bed After Conversion (if line 25 = "NO", line 31 / line 24) (if line 25 = "YES", Max of 450, Min of 300)	337
35 Total Allowable Square Feet After Conversion (if line 25 = "NO", line 31) (if line 25 = "YES", line 34 x line 24)	27,300
36 Annualized Base Year Cost Report Resident Days (line 3 annualized)	22,291
37 70% of Bed Days Available after Conversion (70% x line 24 x 365)	20,696
38 Greater of Annualized Resident Days or 70% Minimum Occupancy after Conversion (greater of lines 36 and 37)	22,291
39 Gross Facility Value After Conversion	\$ 4,657,056
40 Allowed Weighted Age of Facility	24
41 Depreciation % (1.25% per year)	30%
42 Depreciated Facility Value After Conversion	\$ 3,374,435
43 Rental Fee	9.25%
44 Annual FRV After Conversion	\$ 312,135
45 FRV Per Diem after Conversion Effective 01/01/2010 (line 44 / line 38)	\$ 14.00

**NOTE: The additional \$5 per diem for each Medicaid Resident in a Converted Private Room is Effective 01/01/2010**

### Subsequent Square Footage Change

46 Date of Square Footage Change after Conversion	12/1/2009
47 Date Re-Age Will Be Effective	1/1/2010
48 Was a New Bulding Opened After the Private Room Conversion?	NO
49 Square Footage Prior to Change (line 28)	26,912
50 Change in Square Footage (re-age request)	(1,000)
51 Additional Change in Licensed Beds (NOT related to conversion - separate re-age request)	(5)
52 Revised Square Footage (line 49 + line 50)	25,912
53 Square Feet per Bed (Prior to Conversion) (line 52 / (line 5 + line 51))	301
54 Allowable Square Feet per Bed (Prior to Conversion) (Max 450, Min 300)	301
55 Total Allowable Square Feet (Prior to Conversion) (line 54 x (line 5 + line 51))	25,912
56 Total Square Footage (line 52)	25,912
57 Square Feet per Bed (After Conversion) (line 56 / (line 24 + line 51))	341
58 Allowable Square Feet per Bed (After Conversion) (if line 48 = NO, line 55 / (line 24 + line 51)) (if line 48 = YES, Max 450, Min 300)	341
<b>Total Allowable Square Feet to be Used in FRV Rate Effective 01/01/2010 (if line 48 = NO, line 55) (if line 48 = YES, line 58 x (line 24 + line 51))</b>	<b>25,912</b>

### Next Rebase Calculations

60 Next Rebase Date	7/1/2010
61 7/1/2010 Rebase Cost Report Period Beginning	7/1/2007
62 7/1/2010 Rebase Cost Report Period Ending	6/30/2008
63 Percentage of Period Before 10/01/2009 (Date of Conversions)	100.00%
64 07/01/2010 Base Year Cost Report Total Resident Days	24,000
65 07/01/2010 Base Year Cost Report Total Bed Days Available	31,390
66 Base Year Bed Days Available Excluding Beds Converted (line 65 - (line 32 x 365 x line 63))	27,740
67 Base Year Occupancy After Conversion (lesser of line 65 / line 66 and 100%)	86.5177%
68 Annualized Resident Days Using Base Year Occupancy % After Conversion (line 67 x (line 24 + line 51) x 365)	24,000
69 70% of Current Licensed Bed Days Available (70% x (line 24 + line 51) x 365)	19,418
<b>70 Days to Use in FRV Per Diem Calculation at 07/01/2010 Rebase (Greater of Line 68 or Line 69)</b>	<b>24,000</b>

# **APPENDIX X**

# **LOUISIANA NURSING FACILITY RULES**

**AUGUST 20, 2002**  
**CASE MIX RULE**

with Medicare deadlines, including extensions. Hospitals that fail to timely file Medicare cost reports will be assumed to be ineligible for disproportionate share payments. Only hospitals that return timely disproportionate share qualification documentation will be considered for disproportionate share payments. For hospitals with distinct part psychiatric units, qualification is based on the entire hospital's utilization.

F. - I. ...

III. Reimbursement Methodologies

B. Small Rural Hospitals

1. A small rural hospital is a hospital (excluding a long-term care hospital, rehabilitation hospital or free-standing psychiatric hospital, but including distinct part psychiatric units) that meets the following criteria:

a. had no more than 60 hospital beds as of July 1, 1994 and is located in a parish with a population of less than 50,000 or in a municipality with a population of less than 20,000; or

b. meets the qualifications of a sole community hospital under 42 CFR §412.92(a); or

c. had no more than 60 hospital beds as of July 1, 1999 and is located in a parish with a population of less than 17,000 as measured by the 1990 census; or

d. had no more than 60 hospital beds as of July 1, 1997 and is a publicly owned and operated hospital that is located in either a parish with a population of less than 50,000 or a municipality with a population of less than 20,000; or

e. had no more than 60 hospital beds as of June 30, 2000 and is located in a municipality with a population, as measured by the 1990 census, of less than 20,000; or

f. had no more than 60 beds as of July 1, 1997 and is located in a parish with a population, as measured by the 1990 and 2000 census, of less than 50,000; or

g. was a hospital facility licensed by the department that had no more than 60 hospital beds as of July 1, 1994, which hospital facility has been in continuous operation since July 1, 1994, is currently operating under a license issued by the department, and is located in a parish with a population, as measured by the 1990 census, of less than 50,000.

2. ...

3. Payment is equal to each qualifying rural hospital's pro rata share of uncompensated cost for all hospitals meeting these criteria for the latest filed cost report multiplied by the amount set for each pool. If the cost reporting period is not a full period (12 months), actual uncompensated cost data from the previous cost reporting period may be used on a pro rata basis to equate a full year.

4. ...

C. Large Public Non-State Hospitals

1. A large public non state hospital is defined as any hospital owned by a parish, city or other local government agency or instrumentality; and not included in Section III.A. or B of the May 20, 1999 Rule. A qualifying hospital may be a long term hospital.

2. Qualifying hospitals must meet the qualifying criteria contained in Section II.E and either Section II.A, B, or C of the May 20, 1999 Rule. Qualifying hospitals must maintain a log documenting the hospital's provision of uninsured care as directed by the department. Issuance of the

disproportionate share payment is contingent on the public non state hospital certifying public funds as representing expenditures eligible for FFP in compliance with Act 12 of the 2001 Regular Session of the Louisiana Legislature and appropriation of funding by the Louisiana Legislature.

3. Disproportionate share payments to each qualifying public non state hospital are equal to that hospital's pro rata share of uncompensated costs for all hospitals meeting these criteria for the latest filed cost report multiplied by the amount set for this pool. Payment shall not exceed each qualifying hospital's actual uncompensated costs as defined in Section I.G of the May 20,1999 Rule. If the cost reporting period is not a full period (12 months), actual uncompensated cost data for the previous cost reporting period may be used on a pro rata basis to equate to a full year.

D. All Other Hospitals (private rural and urban hospitals, free-standing psychiatric hospitals exclusive of state hospitals, rehabilitation hospitals and long-term care hospitals)

1. - 2.c. ...

Implementation of this Rule shall be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

David W. Hood  
Secretary

0208#085

**RULE**

**Department of Health and Hospitals  
Office of the Secretary  
Bureau of Health Services Financing**

Nursing Facilities  
Reimbursement Methodology  
(LAC 50:VII.1301-1311)

Editor's Note: The following Rule is being repromulgated to correct final Rule text. The original Rule may be viewed on pages 1472-1476 of the June 20, 2002 edition of the *Louisiana Register*.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following Rule under the Medical Assistance Program as authorized by R.S. 46:2742 and R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is adopted in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

**Rule**

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing repeals the June 20, 1984 Rule and 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.

#### Title 50

### PUBLIC HEALTHC MEDICAL ASSISTANCE

#### Part VII. Long Term Care Services

##### Subpart 1. Nursing Facilities

#### Chapter 13. Reimbursement

##### §1301. Definitions

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

*Base Resident-Weighted Median Costs and Prices*Cthe resident-weighted median costs and prices calculated in accordance with §1305 of this rule during rebase years.

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

1. attributable to depreciation;
2. capital related interest;
3. rent; and/or
4. lease and amortization expenses.

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

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

*Case-Mix Index*Ca numeric score within a specific range that identifies the relative resources used by similar residents and represents the average resource consumption across a population or sample.

*Cost Neutralization*Crefers 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.

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

1. registered nurse (RN), licensed practical nurse (LPN) and nurse aide salaries and wages;
2. a proportionate allocation of allowable employee benefits; and
3. the direct allowable cost of acquiring RN, LPN and nurse aide staff from outside staffing companies.

*Facility Cost Report Period Case-Mix Index*Cthe 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.

Example: A January 1, 2001-December 31, 2001 cost report period would use the facility-wide average case-mix indices for quarters beginning January 1, 2001, April 1, 2001, July 1, 2001 and October 1, 2001.

When this system is implemented, if four quarters of acuity data are not available that coincide with the cost report period, a two quarter average of acuity data that most closely matches the cost reporting period will be used.

*Facility-Wide Average Case-Mix Index*Cthe simple average, carried to four decimal places, of all resident case-mix indices based on the first day of each calendar quarter.

*Index Factor*Cwill be based on the *Skilled Nursing Home without Capital Market Basket Index* published by Data

Resources Incorporated (DRI-WEFA), or a comparable index if this index ceases to be published.

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

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

*Resident-Day-Weighted Median Cost*Ca 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.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 28:1473 (June 2002), repromulgated LR 28:1790 (August 2002).

##### §1303. Cost Reports

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

1. 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.

2. In addition to filing the Medicare cost report, nursing facility providers must also file supplemental schedules designated by the Bureau.

3. Providers of skilled nursing-infectious disease (SN-ID) and skilled nursing-technology dependent care (SN-TDC) services must file additional supplemental schedules designated by the Bureau documenting the incremental cost of providing SN-ID and SN-TDC services to Medicaid recipients.

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

B. Cost reports must be prepared in accordance with the cost reporting instructions adopted by the Medicare Program using the definition of allowable and nonallowable cost contained in the Medicare/Medicaid provider reimbursement manual, with the following exceptions.

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

2. If the facility experiences unavoidable difficulties in preparing the cost report by the prescribed due date, a filing extension may be requested. A filing extension request must be submitted to the Bureau prior to the cost report due date. Facilities filing a reasonable extension request will be granted an additional 30 days to file their cost report.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1473 (June 2002), repromulgated LR 28:1790 (August 2002).

**§1305. Rate Determination**

A. For dates of service on or after July 1, 2002, each nursing facility's rate for skilled nursing (SN), intermediate care I (IC-I) and intermediate care II (IC-II) services shall be the daily rates for these services in effect on June 30, 2002 as adjusted by legislative appropriations for State Fiscal Year 2003.

B. 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 recently 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.

C. Each facility's Medicaid daily rate is calculated as:

1. the sum of the facility's direct care and care related price;
2. the statewide administrative and operating price;
3. each facility's capital rate component; and
4. each facility's pass-through rate component.

D. Determination of Rate Components

1. Facility Specific Direct Care and Care Related Component. This portion of a facility's rate shall be determined as follows.

a. 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.

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

c. 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.

d. 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.

e. 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. 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. This enhancement is made in accordance with §1305.D.5. of this Rule.

f. 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 §1305.D.1.c. 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. The Department may evaluate, in conjunction with the nursing facility industry, whether to use the Medicaid average case mix index to adjust the statewide price on a quarterly basis. However, using the Medicaid average case mix index can not be effective prior to July 1, 2005. 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.

g. 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 §1305.D.1.c. 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. The Department may evaluate, in conjunction with the nursing facility industry, whether to use the Medicaid average case mix index to adjust the statewide floor on a quarterly basis. However, using the Medicaid average case mix index can not be effective prior to July 1, 2005. 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.

h. 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 cost and the direct care and care related floor. If the cost the facility incurred is less than the floor, the facility shall remit to the Bureau the difference between these two amounts times the number of Medicaid days paid during the portion of the cost reporting period after December 31, 2002.

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

a. 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.

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

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

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

a. 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 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.

b. 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 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. A nursing facility's fair rental value per diem is calculated as follows.

i. 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.

ii. 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.

iii. 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.

iv. 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, and to reduce the age 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. If a facility performed a major renovation/replacement project (defined as a project with capitalized cost equal to or greater than \$500 per bed), the cost of the renovation project completed during a 24-month period prior to a July 1 rate year will be used to determine the equivalent number of new beds that project represents. The equivalent number of new beds would then be used to determine the weighted average age of all beds for this facility. The equivalent number of new beds from a renovation project will be determined by dividing the cost of the renovation/replacement project by the accumulated depreciation per bed of the facility's existing beds immediately before the renovation project.

4. Pass-Through Component of the Rate. The pass-through component of the rate is calculated as follows.

a. 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.

5. Adjustment to the Rate. Adjustments to the Medicaid daily rate may be made when changes occur, that will eventually be recognized in updated cost report data (such as a change in the minimum wage, a change in FICA or a utility rate change). These adjustments would be effective until the next rebasing of cost report data or until such time as the cost reports fully reflect the change. Adjustments to rates may also be made when legislative appropriations would increase or decrease the rates calculated in accordance with this rule. The Secretary of the Department of Health and Hospitals makes the final determination as to the amount and when adjustments to the rates are warranted.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1474 (June 2002), repromulgated LR 28:1791 (August 2002).

#### **§1307. 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.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1475 (June 2002), repromulgated LR 28:1792 (August 2002).

**§1309. State-Owned or Operated and Nonstate Government-Owned or Operated Facilities**

A. Nonstate government-owned or operated nursing facilities participating in an inter-governmental transfer program and state-owned or operated nursing facilities will be paid a prospective reimbursement rate. The aggregate prospective payment rates for these facilities will be calculated on a quarterly basis using the state's best estimate of what facilities would be paid under Medicare's prospective payment system for skilled nursing facilities. The acuity measurements used in the quarterly rate calculations will be the acuity of each facility's Medicaid residents, as determined under Medicare's 44 RUG classification methodology. Adjustments to these gross Medicare prospective payment rates will be made to account for differences in coverage between the Medicare and Medicaid programs.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1475 (June 2002), repromulgated LR 28:1793 (August 2002).

**§1311. New Facilities and Changes of Ownership of Existing Facilities**

A. New facilities are those entities whose beds have not previously been licensed and certified to participate in the Medicaid program. New facilities will be reimbursed in accordance with this rule using the statewide-wide average case mix index to adjust the state-wide direct care and care related price and the state-wide direct care and care related floor. After the first full calendar quarter of operation, the state-wide direct care and care related price and the state-wide direct care and care related floor shall be adjusted by

the facility's case mix index calculated in accordance with §1305.D.1.f-g and §1307 of this Rule. 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 state-wide average capital rate for all facilities until the actual capital rate for the new facility is determined.

B. A change of ownership exists if the beds of the new owner have previously been licensed and certified to participate 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 and capital data of the prior owner. The new owner's acuity and capital data will be used to determine the facility's rate following the procedures specified in this rule.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1793 (August 2002).

All rate adjustments specified in this rule are contingent upon appropriation by the Louisiana Legislature. Implementation of the provisions of this rule shall be contingent upon the approval of the State Plan Amendment by U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

David W. Hood  
Secretary

0208#108

**RULE**

**Department of Health and Hospitals  
Office of the Secretary  
Bureau of Health Services Financing**

**Professional Services Program  
Physician Services  
Reimbursement Increase**

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted the following Rule in the Medical Assistance Program as authorized by R.S. 46:153 and pursuant to Title XIX of the Social Security Act. This Rule is adopted in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

**Rule**

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing increases reimbursement paid to physicians for certain designated Physicians' Current Procedural Terminology (CPT) procedure codes related to specialty services.

Reimbursement for the following designated CPT-4 codes is increased to 70 percent of the 2002 Medicare allowable fee schedule.

CPT-4 Code	Description
33960	External Circulation Assist
43760	Change Gastrostomy Tube; Simple
57452	Examination of the Vagina
62270	Spinal Fluid Tap, Diagnostic

**DECEMBER 20, 2002**  
**MDS RULE**

**Title 48**  
**PUBLIC HEALTHC GENERAL**  
**Part I. General Administration**  
**Subpart 3. Licensing and Certification**  
**Chapter 45. Ambulatory Surgical Center**

**§4501. Definitions**

**A. Ambulatory Surgical CenterC**

1. an establishment with an organized medical staff of physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, with continuous physician services and registered professional nursing services available whenever a patient is in the facility, which does not provide services or other accommodations for patients to stay overnight, and which offers the following services whenever a patient is in the center:

- a. drug services as needed for medical operations and procedures performed;
- b. provisions for physical and emotional well-being of patients;
- c. provision of emergency services;
- d. organized administrative structure; and
- e. administrative, statistical, and medical records.

2. *Ambulatory Surgical Center* also means a treatment center that is operated primarily for the purpose of offering stereotactic radiosurgery by use of a Gamma Knife or similar neurosurgical tool.

**B. StandardsC**the rules, regulations and minimum standards duly adopted and promulgated by the Department of Health and Hospitals with approval of the secretary.

**C. DivisionC**the Bureau of Health Services Financing of the Department of Health and Hospitals.

**D. DepartmentC**the Department of Health and Hospitals.

**E. SecretaryC**the secretary of the Department of Health and Hospitals of the state of Louisiana.

F. - Q.4 ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2143.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended LR 14:155 (March 1988), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2536 (December 2002).

**§4503. Agency Responsibilities**

A. Responsibilities for licensing procedures for ambulatory surgical centers shall be accomplished by the Bureau of Health Services Financing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2536 (December 2002).

**§4509. General**

A. Except as otherwise specified in §4571, ambulatory surgical centers shall comply with the following:

1. all licensing requirements contained in this Chapter 45; and
2. all applicable sections of the Guidelines for Design and Construction of Hospital and Health Care Facilities.

B. - N. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2143.

HISTORICAL NOTE: Promulgated by the Department of Health and Human Resources, Office of the Secretary, Division of Licensing and Certification, LR 13:246 (April 1987), amended LR 14:155 (March 1988), amended by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2536 (December 2002)

**§4571. Stereotactic Radiosurgery**

A. Ambulatory surgical centers operated primarily for the purpose of offering stereotactic radiosurgery by use of a Gamma Knife or similar neurosurgical tool are exempt from:

1. the following requirements in this Chapter 45:
  - a. Subsection 4509.L;
  - b. Subsection 4545.B;
  - c. Subsection 4545.D; and

2. Section 9.5.F5.c of the Guidelines for Design and Construction of Hospital and Health Care Facilities, which provides:

a. "Scrub facilities. Station(s) shall be provided near the entrance to each operating room and may service two operating rooms if needed. Scrub facilities shall be arranged to minimize incidental splatter on nearby personnel or supply carts."

B. The exceptions listed in this §4571 do not apply to ambulatory surgical centers performing surgical procedures in conjunction with stereotactic radiosurgery.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2131-2141.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2536 (December 2002).

David W. Hood  
Secretary

0212#102

**RULE**

**Department of Health and Hospitals**  
**Office of the Secretary**  
**Bureau of Health Services Financing**

Nursing Facilities  
Reimbursement Methodology  
Minimum Data Set Verification  
(LAC 50:VII.1301, 1303, 1313 and 1315)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has amended LAC 50:VII.1301 and 1303 and adopted new provisions under the Medical Assistance Program as authorized by R.S. 46:2742 and R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

**Title 50**

**PUBLIC HEALTHC MEDICAL ASSISTANCE**

**Part VII. Long Term Care Services**

**Subpart 1. Nursing Facilities**

**Chapter 13. Reimbursement**

**§1301. Definitions**

\* \* \*

*Calendar QuarterC*a three-month period beginning January 1, April 1, July 1, or October 1.

\* \* \*

**Case Mix Index**Ca numerical value that describes the resident's relative resource use within the groups under the Resource Utilization Group (RUG-III) classification system prescribed by the department based on the resident's MDS 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).

\* \* \*

**Delinquent MDS Resident Assessment**Can MDS assessment that is more than 121 days old, as measured by the R2b date field on the MDS.

\* \* \*

**Minimum Data Set (MDS)**Ca 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 MDS 2.0 or subsequent revisions as approved by the Center for Medicare and Medicaid Services.

**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.

**On-Site MDS Review**Ca systematic official verification, including the final written report of the examination of original medical record documentation supporting resident assessment data.

\* \* \*

**Point-in-Time**Ca report that reflects the residents in the facility on the last day of the previous calendar quarter.

\* \* \*

**RUG-III Resident Classification System**the resource utilization group used to classify residents. When a resident classifies into more than 1 RUG-III group, the RUG-III group with the greatest CMI will be utilized to calculate the facility average CMI and Medicaid average CMI.

**Unsupported MDS Resident Assessment**Can assessment where one or more data items that are used to classify a resident pursuant to the RUG-III, 34-group, resident classification system is not supported according to the MDS supporting documentation guidelines and a different RUG-III classification would result in order for the MDS assessment to be considered "unsupported."

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1473 (June 2002), amended LR 28:1790 (August 2002), LR 28:2536 (December 2002).

### §1303. Cost Reports

A. - A.4. ...

B. Cost reports must be prepared in accordance with the cost reporting instructions adopted by the Medicare Program and using the definition of allowable and non allowable cost

contained in the Medicare/Medicaid provider reimbursement manual, with the following exceptions.

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1473 (June 2002), amended LR 28:1790 (August 2002), LR 28:2537 (December 2002).

### §1313. Verification of Minimum Data Set Assessments

A. 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 CMI report will serve as notice of the MDS assessments transmitted and provide an opportunity for the nursing facility 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 after allowing the facilities a reasonable amount of time to process their corrections (approximately two weeks).

1. If the department or its contractor determines that a nursing facility has delinquent MDS resident assessments, for purposes of determining both average CMIs, such assessments shall be assigned the case mix index associated with the RUG-III group "BC1-Delinquent." A delinquent MDS shall be assigned a CMI value equal to the lowest CMI in the RUG-III classification system.

B. 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. The department shall notify facilities of the MDS reviews not less than two business days prior to the start of the MDS review date and a fax, electronic mail or other form of communication will be provided to the administrator and MDS coordinator on the same date identifying documentation that will be required to be available at the start of the on-site MDS review.

1. The department or its contractor shall review a sample of MDS resident assessments equal to the greater of 20 percent of the occupied bed size of the facility or 10 assessments and shall include those transmitted assessments posted on the most current point-in-time report. The MDS review will determine the percentage of assessments in the sample that are unsupported MDS resident assessments. The department may review additional or alternative MDS assessments, if it is deemed necessary.

2. When conducting the MDS reviews, the department or its contractor shall consider all MDS supporting documentation that is provided by the nursing facility and is available to the RN reviewers prior to the exit conference. MDS supporting documentation that is provided by the nursing facility after the exit conference shall not be considered for the MDS review.

3. Upon request by the department or its contractor, the nursing facility shall be required to produce a computer-generated copy of the transmitted MDS assessment which shall be the basis for the MDS review.

4. After the close of the MDS review, the department or its contractor will submit an MDS review findings report to the facility within 10 business days following the exit conference.

5. The following corrective action will apply to those facilities with unsupported MDS resident assessments identified during an on-site review.

a. If the percentage of unsupported assessments in the initial on-site review sample is greater than 25 percent, the sample shall be expanded to include another 20 percent of remaining resident assessments.

b. If the percentage of unsupported assessments in the total sample is equal to or less than the threshold percentage as shown in Column (B) of the table in Subparagraph d below, no corrective action will be applied.

c. If the percentage of unsupported assessments in the total sample is greater than the threshold percentage as shown in Column (B) of the table in Subparagraph d below, the RUG-III classification shall be recalculated for the unsupported MDS assessments based upon the available documentation obtained during the review process. The facility's CMI and resulting Medicaid rate shall be recalculated for the quarter in which the point-in-time roster was used to determine the Medicaid rate. A follow-up review process described in Subparagraphs d and e may be utilized at the discretion of the department.

d. Those providers exceeding the thresholds [see Column (B) of the table in Subparagraph e] during the initial on-site review will be given 90 days to correct their assessing and documentation processes. A follow-up MDS review may be performed at the discretion of the Department at least 30 days after the facility's 90-day correction period. The department shall notify the facility not less than two business days prior to the start of the MDS review date. A FAX, electronic mail, or other form of communication will be provided to the administrator and MDS coordinator on the same date identifying documentation that must be available at the start of the on-site MDS review.

e. After the follow-up MDS review, if the percentage of unsupported assessments in the total sample is greater than the threshold percentage as shown in Column (B) of the following table, the RUG-III classification shall be recalculated for the unsupported MDS assessments based upon the available documentation obtained during the review process. The facility's CMI and resulting Medicaid rate shall be recalculated for the quarter in which the point-in-time roster was used to determine the Medicaid rate. In addition, facilities found to have unsupported MDS resident assessments in excess of the threshold in Column (B) of the table below may be required to enter into an MDS Documentation Improvement Plan with the department of

Health and Hospitals. Additional follow-up MDS reviews may be conducted at the discretion of the department.

Effective Date (A)	Threshold Percent (B)
January 1, 2003	Educational
January 1, 2004	40%
January 1, 2005	35%
January 1, 2006	25%

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2537 (December 2002).

**§1315. Appeal Process**

A. If the facility disagrees with the review findings, a written request for an informal reconsideration must be submitted to the department or its contractor within 15 business days of the facility's receipt of the MDS review findings report. Otherwise, the results of the MDS review findings report are considered final and not subject to appeal. The department or its contractor will review the facility's informal reconsideration request within 10 business days and will send written notification of the final results of the reconsideration to the facility. No appeal of findings will be accepted until after communication of final results of the informal reconsideration process.

B. The provider has the right to request an appeal within 30 days of the written notice of the results of the informal reconsideration. Such request must be in writing to the Appeals Section. The request must contain a statement and be accompanied by supporting documents setting forth with particularity those asserted discrepancies which the provider contends are in compliance with the agency's regulations and the reasons for such contentions.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2538 (December 2002).

David W. Hood  
Secretary

0212#108

**RULE**

**Department of Insurance  
Office of the Commissioner**

**Regulation 78C Policy Form Filing Requirements  
(LAC 37:XIII.Chapters 59 and 101)**

Under the authority of Louisiana Revised Statutes Title 22, R.S. 49:950 et seq. and R.S. 22:620.A, the Department of Insurance has adopted the following Rule to establish reasonable requirements for insurers who seek to file insurance products in this state for approval. This Rule is necessary to provide for the uniform and practicable administration of the form filing, review and approval requirements of the Louisiana Insurance Code and to assist all insurers doing business in the state of Louisiana in

**APRIL 20, 2004 CASE  
MIX RATE  
REDUCTION**

General Appropriation Act, which states: "The Secretary shall implement reductions in the Medicaid program as necessary to control expenditures to the level approved in this schedule. The Secretary is hereby directed to utilize various cost containment measures to accomplish these reductions, including but not limited to, pre-certification, pre-admission screening, and utilization review, and other measures as allowed by federal law." This Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

**Title 50**  
**PUBLIC HEALTH—MEDICAL ASSISTANCE**  
**Part VII. Long Term Care Services**  
**Subpart I. Nursing Facilities**  
**Chapter 13. Reimbursement**  
**§1306. Reimbursement Adjustment**

A. Effective for dates of service on or after January 1, 2004, for state fiscal year 2003-2004 only, each private nursing facility's per diem case mix adjusted rate shall be reduced by \$0.67.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:804 (April 2004).

Implementation of the provisions of this Rule shall be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Frederick P. Cerise, M.D., M.P.H.  
Secretary

0404#091

**RULE**

**Department of Revenue  
Policy Services Division**

Books of the Corporation  
(LAC 61:I.320)

Under the authority of R.S. 47:604, R.S. 47:605 and R.S. 47:1511 and in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq., the Department of Revenue, Policy Services Division, has adopted LAC 61:I.320 to define "books of the corporation" relative to the computation of the corporation franchise tax.

This regulation will provide the definition of "books of the corporation" by formally adopting the federal provisions set forth in Internal Revenue Service regulations section 1.56-1(c). The "books of the corporation" are not defined in prior or current statutes and regulations. Previously, the department has informally applied these federal provisions to determine the "books of the corporation" and prioritize records to be used in the calculation of the corporation franchise tax.

**Title 61**

**REVENUE AND TAXATION**

**Part I. Taxes Collected and Administered  
by the Secretary of Revenue**

**Chapter 3. Corporation Franchise Tax**

**§320. Books of the Corporation**

A. Generally the "books of the corporation" are financial statements that will include an income statement, a balance sheet (listing assets, liabilities, and owners equity including changes thereto), and other appropriate information. The following may be considered applicable financial statements.

1. Statement required to be filed with the Securities and Exchange Commission (SEC). A financial statement that is required to be filed with the Securities and Exchange Commission.

2.a. Certified audited financial statement. A certified audited financial statement that is used for credit purposes, for reporting to shareholders or for any other substantial non-tax purpose. Such a statement must be accompanied by the report of an independent (as defined in the American Institute of Certified Public Accountants Professional Standards, Code of Professional Conduct, Rule 101 and its interpretations and rulings) certified public accountant or, in the case of a foreign corporation, a similarly qualified and independent professional who is licensed in any foreign country. A financial statement is "certified audited" for purposes of this Section if it is:

i. certified to be fairly presented (an unqualified or "clean" opinion);

ii. subject to a qualified opinion that such financial statement is fairly presented subject to a concern about a contingency (a qualified "subject to" opinion);

iii. subject to a qualified opinion that such financial statement is fairly presented, except for a method of accounting with which the accountant disagrees (a qualified "except for" opinion); or

iv. subject to an adverse opinion, but only if the accountant discloses the amount of the disagreement with the statement.

b. Any other statement or report, such as a review statement or a compilation report that is not subject to a full audit is not a certified audit statement.

3. A financial statement provided to a government regulator. A financial statement that is required to be provided to the federal government, or any agency thereof (other than the Securities and Exchange Commission), a state government or agency thereof, or a political subdivision of a state or agency thereof. Except as otherwise provided herein, an income tax return, franchise tax return or other tax return prepared solely for the purpose of determining any tax liability that is filed with a federal, state or local government or agency cannot be an applicable financial statement.

4. Other financial statements. A financial statement that is used for credit purposes, for reporting to shareholders, or for any other substantial non-tax purpose, even though

**JULY 20, 2005**  
**CASE MIX RULE**  
**(DME ADD-ON)**

**RULE**

**Department of Health and Hospitals  
Office of the Secretary  
Bureau of Health Services Financing**

Nursing Facilities—Reimbursement Methodology  
(LAC 50:VII.1305 and 1309)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends LAC:50.VII.1305 and 1309 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

**Title 50**

**PUBLIC HEALTH—MEDICAL ASSISTANCE**

**Part VII. Long Term Care Services**

**Subpart 1. Nursing Facilities**

**Chapter 13. Reimbursement**

**§1305. Rate Determination**

A.- D.4.a. ...

b. Effective August 1, 2005, the pass-through rate will include a flat statewide fee for the cost of durable medical equipment and supplies required to comply with the plan of care for Medicaid recipients residing in nursing facilities.

D.5. ...

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

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1474 (June 2002), repromulgated LR 28:1791 (August 2002), amended LR 31:1596 (July 2005).

**§1309. State-Owned or Operated and Nonstate Government-Owned or Operated Facilities**

A. ...

B. State-owned or operated nursing facilities are paid a prospective reimbursement rate. Effective August 1, 2005, this 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.

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

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1476 (June 2002), repromulgated LR 28:1793 (August 2002), amended LR 30:53 (January 2004) LR 31:1596 (July 2005).

Implementation of the provisions of this Rule shall be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Frederick P. Cerise, M.D., M.P.H.  
Secretary

0507#076

**RULE**

**Department of Health and Hospitals  
Office of the Secretary  
Bureau of Health Services Financing**

Professional Services Program—Nurse Practitioners,  
Nurse-Midwives, and Clinical Nurse Specialists

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing promulgates the following Rule under the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the Administrative Procedure Act, R.S.49:950 et seq.

**Rule**

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts the following provisions governing services rendered by nurse practitioners, nurse-midwives and clinical nurse specialists under the Professional Services Program.

In order to participate in the Medicaid Program, a nurse practitioner, nurse-midwife, or clinical nurse specialist must enroll as a provider and obtain an individual Medicaid provider number. Effective for dates of service on or after August 1, 2005, all claims filed for reimbursement must identify the nurse practitioner, nurse-midwife, or clinical nurse specialist as the attending provider if he/she is employed by or under contract with a Medicaid enrolled physician or physician group.

Unless otherwise excluded by the Medicaid Program, service coverage shall be determined by individual licensure, scope of practice, and the terms of the physician collaborative agreement. The collaborating physician must be a Medicaid enrolled provider. Collaborative agreements must be available for review upon request by authorized representatives of the Medicaid Program.

The reimbursement rate shall be 80 percent of the rate on file on the professional services fee schedule for covered services and 100 percent of the rate on file for a designated group of procedures as determined by the Medicaid Program.

Nurse practitioners, nurse-midwives, and clinical nurse specialists shall not bill separately for their services when they are employed by or under contract with Medicaid enrolled providers whose reimbursement is based on cost reports that include the cost of their salaries.

Implementation of the provisions of this Rule shall be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Frederick P. Cerise, M.D., M.P.H.  
Secretary

0507#073

**DECEMBER 20, 2006  
CASE MIX CHANGES**

preparedness plan in the event of the occurrence of a declared disaster or other emergency.

B. At a minimum, the nursing facility shall have a written plan that describes:

1. the evacuation of residents to a safe place either within the nursing facility or to another location;

2. the delivery of essential care and services to residents, whether the residents are housed off-site or when additional residents are housed in the nursing facility during an emergency;

3. the provisions for the management of staff, including distribution and assignment of responsibilities and functions, either within the nursing facility or at another location;

4. a plan for coordinating transportation services required for evacuating residents to another location; and

5. the procedures to notify the resident's family or responsible representative if the resident is evacuated to another location.

C. The nursing facility's plan shall be activated at least annually, either in response to an emergency or in a planned drill. The nursing facility's performance during the activation of the plan shall be evaluated and documented. The plan shall be revised if indicated by the nursing facility's performance during the planned drill.

D. The nursing facility's plan shall be reviewed and approved by the parish OEP, utilizing appropriate community-wide resources.

E. The plan shall be available to representatives of the Office of the State Fire Marshal.

F.1. In the event that a nursing facility evacuates, temporarily relocates or temporarily ceases operation at its licensed location as a result of an evacuation order issued by the parish OEP and sustains damages due to wind, flooding or power outages longer than 48 hours, the nursing facility shall not be reopened to accept returning evacuated residents or new admissions until surveys have been conducted by the Office of the State Fire Marshal, the Office of Public Health and the Bureau of Health Services Financing, Health Standards Section.

a. The purpose of these surveys is to assure that the facility is in compliance with the licensing standards in the areas of the structural soundness of the building, the sanitation code and staffing requirements.

b. The Health Standards Section will determine the facility's access to the community service infrastructure, such as hospitals, transportation, physicians, professional services and necessary supplies.

2. If a nursing facility evacuates, temporarily relocates or temporarily ceases operation at its licensed location as a result of an evacuation order issued by the parish OEP and does not sustain damages due to wind, flooding or power outages longer than 48 hours, the nursing facility may be reopened.

G.1. Before reopening at its licensed location, the nursing facility must submit a detailed summary to the licensing agency attesting how the facility's emergency preparedness plan was followed and executed. A copy of the facility's approved emergency preparedness plan must be attached to the detailed summary. The detailed summary must contain, at a minimum:

a. pertinent plan provisions and how the plan was followed and executed;

b. plan provisions that were not followed;

c. reasons and mitigating circumstances for failure to follow and execute certain plan provisions;

d. contingency arrangements made for those plan provisions not followed; and

e. a list of injuries and/or deaths of residents that occurred during the execution of the plan, evacuation and temporary relocation.

2. Before reopening, the nursing facility must receive approval from the licensing agency that the facility was in substantial compliance with the emergency preparedness plan. The licensing agency will review the facility's plan and the detailed summary submitted.

a. If the licensing agency determines from these documents that the facility was in substantial compliance with the plan, the licensing agency will issue approval to the facility for reopening, subject to the facility's compliance with any other applicable rules.

b. If the licensing agency is unable to determine substantial compliance with the plan from these documents, the licensing agency may conduct an on-site survey or investigation to determine whether the facility substantially complied with the plan.

c. If the licensing agency determines that the facility failed to comply with the provisions of its plan, the facility shall not be allowed to reopen.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2009.1-2116.4.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 24:49 (January 1998), amended LR 32:2261 (December 2006).

Frederick P. Cerise, M.D., M.P.H.  
Secretary

0612#089

## RULE

### Department of Health and Hospitals Office of the Secretary Bureau of Health Services Financing

Nursing Facilities—Reimbursement Methodology  
(LAC 50:VII.1301-1305, 1309, 1311 and 1317)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends LAC 50:VII.1301-1305, 1309, 1311, and adopts §1317 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

#### Title 50

### PUBLIC HEALTH—MEDICAL ASSISTANCE

#### Part VII. Long Term Care Services

##### Subpart 1. Nursing Facilities

#### Chapter 13. Reimbursement

##### §1301. Definitions

\* \* \*

*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 MDS review.

Example: A January 1, 2001-December 31, 2001 cost report period would use the facility-wide average case-mix indices calculated for April 1, 2001, July 1, 2001, October 1, 2001 and January 1, 2002.

1. When this system is implemented, if four quarters of acuity data are not available that coincide with the cost report period, a two-quarter average of acuity data that most closely matches the cost reporting period will be used.

*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 first 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.

\* \* \*

*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.

*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.

\* \* \*

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1473 (June 2002), repromulgated LR 28:1790 (August 2002), amended LR 28:2537 (December 2002), LR 32:2262 (December 2006).

### **§1303. Cost Reports**

A. ...

1. 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, hereafter referred to as the Medicare cost report. 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.

2. 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.

3. Providers of skilled nursing-infectious disease (SN-ID), skilled nursing-technology dependent care (SN-TDC)

and skilled nursing neurological rehabilitation treatment program (SN-NRTP) services must file additional supplemental schedules designated by the bureau documenting the incremental cost of providing SN-ID, SN-TDC and SN-NRTP services to Medicaid recipients.

4. ...

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

1. - 2. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1473 (June 2002), repromulgated LR 28:1790 (August 2002), amended LR 28:2537 (December 2002), LR 32:2263 (December 2006).

### **§1305. Rate Determination**

A. ...

B. 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.

C. - C.2. ...

3. each facility's capital rate component;
4. each facility's pass-through rate component;
5. adjustments to the rate; and
6. the statewide durable medical equipment price.

D. - D.1d. ...

e. 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.

f. 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 §1305.D.1.c. 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.

g. 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 §1305.D.1.c. 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.

h. 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.

Example: A May 1, 2003–April 30, 2004 cost report period would use the average of the per diem floor calculations for April 1, 2003 (weighted using 61 days), July 1, 2003 (weighted using 92 days), October 1, 2003 (weighted using 92 days), January 1, 2004 (weighted using 91 days) and April 1, 2004 (weighted using 30 days).

2. - 3. ...

a. 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.

b. 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.

i. - ii. ...

iii. 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.

iv. 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.

v. 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 the project represents. The equivalent number of new beds from a renovation/improvement 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.

(a). 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.

(b). 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 by the department. All valid requests will become part of the quarterly case-mix FRV rate calculation beginning January 1, 2007.

4. - 4.a. ...

b. Effective August 1, 2005, the pass-through rate will include a flat statewide fee for the cost of durable medical equipment and supplies required to comply with the plan or care for Medicaid recipients residing in nursing facilities. The flat statewide fee shall remain in place until the cost of the durable medical equipment is included in rebase cost reports, as determined under §1305.B, at which time the department may develop a methodology to incorporate the durable medical equipment cost in to the case-mix rate.

5. Adjustment to the Rate. Adjustments to the Medicaid daily rate may be made when changes occur, that will eventually be recognized in updated cost report data (such as a change in the minimum wage, a change in FICA or a utility rate change). These adjustments would be effective until the next rebasing of cost report data or until such time as the cost reports fully reflect the change. 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 parameters established in this rule, by reducing the reimbursement rate paid to each nursing facility using an equal amount per patient day.

E. All capitalized costs related to the installation or extension of supervised automatic fire sprinkler systems or two-hour 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 §1317.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1474 (June 2002), repromulgated LR 28:1791 (August 2002), amended LR 31:1596 (July 2005), LR 32:2263 (December 2006).

#### **§1309. State-Owned or Operated and Non-State Government-Owned or Operated Facilities**

##### **A. Services Provided on or Before June 30, 2005**

1. Non-state government-owned or operated nursing facilities will be paid a prospective reimbursement rate. Each facility will receive a Medicaid base rate calculated in accordance with other sections of this rule. Nonstate government-owned or operated nursing facilities may also receive a supplemental Medicaid payment on a quarterly basis. The aggregate supplemental payments for these facilities, calculated on a quarterly basis, will be the state's best estimate of what nonstate government-owned or operated facilities would be paid under Medicare's prospective payment system for skilled nursing facilities less

the aggregate Medicaid base payments for these facilities. The acuity measurements used in the supplemental Medicaid payment calculations will be the acuity of each facility's Medicaid residents, as determined under Medicare's 44 RUG classification methodology. Adjustments to the aggregate supplemental Medicaid payments will be made to account for differences in coverage between the Medicare and Medicaid programs.

##### **B. Services after June 30, 2005**

1. Non-state government-owned or operated nursing facilities will be paid a case-mix reimbursement rate in accordance with §1305.C.

2. 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 annually on July 1, 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.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1476 (June 2002), repromulgated LR 28:1793 (August 2002), amended LR 30:53 (January 2004), LR 31:1596 (July 2005), LR 32:2265 (December 2006).

#### **§1311. New Facilities, Changes of Ownership of Existing Facilities and Existing Facilities with Disclaimer or Non-Filer Status**

A. 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 in accordance with this rule 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 §1305.D.1c. 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 §1305.D.1.f-g and §1307 of this rule. 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.

B. 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 this rule.

C. Existing facilities with disclaimer status includes any facility that receives a qualified audit opinion or disclaimer on the cost report used for rebase under §1305.B. Facilities with a disclaimed cost report status may have adjustments made to their rates based on an evaluation by the secretary of the department.

D. Existing facilities with non-filer status includes any facility that fails to file a complete cost report in accordance with §1303. These facilities will have their case-mix rates adjusted as follows.

1. 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.

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

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

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1793 (August 2002), amended LR 32:2265 (December 2006).

#### **§1317. Reimbursement for Fire Sprinkler Systems and Two-Hour Rated Wall Installations**

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

1. 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.

2. 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.

a. 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. The Medicaid reimbursement shall be determined as follows.

1. 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.

2. 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.

3. 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 and additional component of their Medicaid daily rate for five years.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2266 (December 2006).

Frederick P. Cerise, M.D., M.P.H.  
Secretary

0612#077

#### **RULE**

#### **Department of Health and Hospitals Office of the Secretary Bureau of Health Services Financing**

#### **Rural Health Clinics (LAC 50:XI.Chapters 161-167)**

Editor's Note: This Rule is being repromulgated due to an error upon submission. The original Rule may be viewed on pages 1904-1905 in the October 2006 edition of the *Louisiana Register*.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts LAC 50:XI.Chapters 161-167 under the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

#### **Title 50**

#### **PUBLIC HEALTH—MEDICAL ASSISTANCE**

#### **Part XI. Clinic Services**

#### **Subpart 15. Rural Health Clinics**

#### **Chapter 161. General Provisions**

#### **§16101. Purpose**

A. The Rural Health Clinic (RHC) Act of 1977 authorized the development of rural health clinics to encourage and stabilize the provision of outpatient primary care in rural areas through cost-based reimbursement.

B. Rural health clinic regulations distinguish between two types of rural health clinics.

1. The independent RHC is a free-standing practice that is not part of a hospital, skilled nursing facility, or home health agency.

2. The provider-based RHC is an integral and subordinate part of a hospital, skilled nursing facility, or home health agency.

C. Rural health clinics improve the health status of Louisiana residents in rural and underserved areas by

**FEBRUARY 20, 2007**  
**CASE MIX WAGE**  
**ADD-ON**

## DECLARATION OF EMERGENCY

### Department of Health and Hospitals Office of the Secretary Bureau of Health Services Financing

#### Nursing Facilities—Direct Support Professionals Wage Enhancement (LAC 50:VII.1305)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends LAC 50:VII.1305 under the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopted a Rule to establish a prospective payment system 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 (*Louisiana Register*, Volume 28, Number 8). The August 20, 2002 Rule was subsequently amended to adopt provisions governing a quarterly adjustment of individual nursing facility rates based on overall case mix and to allow for the offset of installation costs for automatic fire sprinkler systems and two-hour rated walls in Medicaid-certified nursing facilities (*Louisiana Register*, Volume 32, Number 12). This Emergency Rule is being promulgated to amend the provisions of the December 20, 2006 Rule governing the reimbursement methodology for nursing facilities by increasing the reimbursement paid to providers to implement a wage enhancement for direct care staff employed with the nursing facility. It is the intent that this wage enhancement be paid to the direct care staff.

This action is being taken to promote the health and well-being of nursing facility residents by assuring continued access to services through assisting providers to recruit and retain sufficient direct care staff. It is estimated that implementation of this Emergency Rule will increase expenditures in the Medicaid Program by approximately \$11,476,836 for state fiscal year 2006-2007.

Effective February 9, 2007, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for nursing facilities by increasing the reimbursement paid to providers to implement a wage enhancement for direct care staff.

#### Title 50

### PUBLIC HEALTH—MEDICAL ASSISTANCE

#### Part VII. Long Term Care Services

##### Subpart 1. Nursing Facilities

#### Chapter 13. Reimbursement

#### §1305. Rate Determination

##### A. - D.1.h.Example ...

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

of the floor calculations. It is the intent that this wage enhancement be paid to the direct care staff.

##### D.2. - E. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1474 (June 2002), repromulgated LR 28:1791 (August 2002), amended LR 31:1596 (July 2005), LR 32:2263 (December 2006), LR 33:

Implementation of the provisions of this Rule shall be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Interested persons may submit written comments to Jerry Phillips, Department of Health and Hospitals, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Frederick P. Cerise, M.D., M.P.H.  
Secretary

0702#026

## DECLARATION OF EMERGENCY

### Department of Health and Hospitals Office of the Secretary Bureau of Health Services Financing

#### Targeted Case Management Nurse Family Partnership Program (LAC 50:XV.11101-11103)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends LAC 50:XV.11101-11103 under the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing clarified the provisions governing the Nurse Family Partnership (NFP) Program by adopting all existing Rules in codified format in Title 50 of the *Louisiana Administrative Code* (*Louisiana Register*, Volume 30, Number 5). The Nurse Family Partnership Program provides case management services to a targeted population group composed of first-time mothers in certain Department of Health and Hospitals (DHH) administrative regions. The bureau amended the May 20, 2004 Rule to expand the DHH administrative regions served and to amend the eligibility criteria and staffing qualifications (*Louisiana Register*, Volume 31, Number 8). The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) has provided clarification that eligibility for targeted case management services is not transferable between target groups. In compliance with the CMS directive, the bureau amended the August 20, 2005 Rule to clarify that the

**JUNE 20, 2007**  
**NURSING FACILITY**  
**EVACUATION**  
**COSTS**

specific data is required after July 1, 2003. Hospitals shall annually submit:

1. an attestation that patients whose care is included in the hospitals' net uncompensated cost are not Medicaid eligible at the time of registration; and

2. supporting patient-specific demographic data that does not identify individuals, but is sufficient for audit of the hospitals' compliance with the Medicaid ineligibility requirement as required by the department, including:

- a. patient age;
- b. family size;
- c. number of dependent children; and
- d. household income.

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

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 33:

Implementation of the provisions of this Rule shall be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Interested persons may submit written comments to Jerry Phillips at Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to all inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Frederick P. Cerise, M.D., M.P.H.  
Secretary

0706#063

## **DECLARATION OF EMERGENCY**

### **Department of Health and Hospitals Office of the Secretary Bureau of Health Services Financing**

#### **Nursing Facilities—Evacuation and Temporary Sheltering Costs (LAC 50:VII.1319)**

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts LAC 50:VII.1319 as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopted a Rule to establish a prospective payment system 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 (*Louisiana Register*, Volume 28, Number 8). The August 20, 2002 Rule was subsequently amended to adopt provisions governing a quarterly adjustment of individual nursing facility rates based on overall case mix and allow for the offset of installation costs for automatic fire sprinkler systems and two-hour rated walls in Medicaid-

certified nursing facilities (*Louisiana Register*, Volume 32, Number 12).

Act 540 of the 2006 Regular Session of the Louisiana Legislature directed the department, in consultation with the Governor's Office of Homeland Security, to adopt provisions governing emergency preparedness requirements for nursing facilities, including facility-specific reimbursement for documented and allowable evacuation and temporary sheltering costs of a Medicaid-certified nursing facility. In compliance with the directives of Act 540, the department by Emergency Rule adopted provisions governing the reimbursement methodology for nursing facilities to provide for the facility-specific reimbursement of evacuation and temporary sheltering costs of Medicaid-certified nursing facilities (*Louisiana Register*, Volume 33, Number 3). This Emergency Rule is being promulgated to continue the provisions of the March 20, 2006 Emergency Rule. This action is being taken to prevent imminent peril to the health and well-being of nursing facility residents who may be evacuated as a result of disasters or other emergencies.

Effective March 20, 2007, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for nursing facilities.

### **Title 50**

## **PUBLIC HEALTH—MEDICAL ASSISTANCE**

### **Part VII. Long Term Care Services**

#### **Subpart 1. Nursing Facilities**

#### **Chapter 13. Reimbursement**

#### **§1319. Evacuation and Temporary Sheltering Costs**

A. 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 reimbursement of its documented and allowable evacuation and temporary sheltering costs.

1. The expense incurred must be in excess of any existing or anticipated reimbursement from any other sources, including the Federal Emergency Management Agency (FEMA) or its successor.

2. Nursing facilities must first apply for evacuation or sheltering reimbursement from all other sources and request that the department apply for FEMA assistance on their behalf.

3. Nursing facilities must submit expense and reimbursement documentation directly related to the evacuation or temporary sheltering of Medicaid nursing home residents to the department.

B. Eligible Expenses. Expenses eligible for reimbursement must occur as a result of an evacuation and be reasonable, necessary, and proper. Eligible expenses are subject to audit at the department's discretion and may include the following:

1. Evacuation Expenses. Evacuation expenses include expenses from the date of evacuation to the date of arrival at a temporary shelter or another nursing facility. Evacuation expenses include:

a. resident transportation and lodging expenses during travel;

b. nursing staff expenses when accompanying residents, including:

- i. transportation;
- ii. lodging; and

iii. additional direct care expenses, when a direct care expense increase of 10 percent or more is documented.

(a). The direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the department.

c. any additional allowable costs as defined in the CMS Publication 15-1 that are directly related to the evacuation and that would normally be allowed under the nursing facility case-mix rate.

2. Non-nursing Facility Temporary Sheltering Expenses. Non-nursing facility temporary sheltering expenses include expenses from the date the Medicaid residents arrive at a non-nursing facility temporary shelter to the date all Medicaid residents leave the shelter. A non-nursing facility temporary shelter includes shelters that are not part of a licensed nursing facility and are not billing for the residents under the Medicaid case-mix reimbursement system or any other Medicaid reimbursement system. Non-nursing facility temporary sheltering expenses may include:

a. additional nursing staff expenses including:

i. lodging; and

ii. additional direct care expenses, when a direct care expense increase of 10 percent or more is documented.

(a). The direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the department.

b. care-related expenses as defined in the nursing facility case-mix rate system and incurred in excess of care-related expenses prior to the evacuation;

c. additional medically necessary equipment such as beds and portable ventilators that are not available from the evacuating nursing facility and are rented or purchased specifically for the temporary sheltered residents; and

i. these expenses will be capped at a daily rental fee not to exceed the total purchase price of the item;

ii. the allowable daily rental fee will be determined by the department;

d. any additional allowable costs as defined in the CMS Publication 15-1 that are directly related to the temporary sheltering and that would normally be allowed under the nursing facility case-mix rate.

3. Host Nursing Facility Temporary Sheltering Expenses. Host nursing facility temporary sheltering expenses include expenses from the date the Medicaid residents are admitted to a licensed nursing facility to the date all temporary sheltered Medicaid residents are discharged from the nursing facility, not to exceed a six-month period.

a. The host nursing facility shall bill for the residents under Medicaid's case-mix reimbursement system.

b. Additional direct care expenses may be submitted when a direct care expense increase of 10 percent or more is documented.

i. The direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the department.

#### C. Payment of Eligible Expenses

1. 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.

a. 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.

2. 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.

3. All eligible expenses documented and allowed under §1319 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.

a. Equipment purchases that are reimbursed on a rental rate under §1319.B.2.c may have their remaining basis included as allowable cost on future costs reports provided that the equipment is in the nursing facility and being used. If the remaining basis requires capitalization under CMS Publication 15-1 guidelines, then depreciation will be recognized.

4. Payments shall remain under the upper payment limit cap for nursing facilities.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 33:

Implementation of the provisions of this Rule shall be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Interested persons may submit written comments to Jerry Phillips, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Frederick P. Cerise, M.D., M.P.H.  
Secretary

0706#064

## DECLARATION OF EMERGENCY

**Department of Health and Hospitals  
Office of the Secretary  
Bureau of Health Services Financing**

Nursing Facility Minimum Licensing Standards  
Emergency Preparedness  
(LAC 48:I.9729)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amends LAC 48:I.9729 as authorized by R.S. 36:254 and R.S. 40:2009.1-2116.4. This Emergency Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

**AUGUST 20, 2007**  
**NURSING FACILITY**  
**PRIVATE ROOM**  
**CONVERSION**

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 1270(B)(6), 1285, and 37:1164(37).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 33:1646 (August 2007).

**§7441. Action against Registration**

A. For noncompliance with any of the provisions of this Chapter the board may, in addition to or in lieu of administrative proceedings against a physician's license, suspend, revoke, or cancel a physician's registration to engage in collaborative drug therapy management or impose such terms, conditions or restrictions thereon as the board may deem necessary or appropriate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 1270(B)(6), 1285, and 37:1164(37).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 33:1646 (August 2007).

**§7443. Unauthorized Practice**

A. Nothing in this Chapter shall be construed as authorizing a pharmacist to issue prescriptions, exercise independent medical judgment, render diagnoses, provide treatment, assume independent responsibility for patient care, or otherwise engage in the practice of medicine as defined in the Medical Practice Act. Any person who engages in such activities, in the absence of medical licensure issued by the board, shall be engaged in the unauthorized practice of medicine and subject to the penalties prescribed by the Medical Practice Act.

B. Any physician who associates with or assists an unlicensed person engage in the practice of medicine shall be deemed to be in violation of R.S. 37:1285(A)(18), providing cause for the board to suspend, revoke, refuse to issue or impose probationary or other restrictions on any license to practice medicine in Louisiana held or applied for by a physician culpable of such violation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 37:1270(A)(1), 1270(B)(6), 1271, 1285, 1286, 1290, and R.S. 37:1164(37).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Board of Medical Examiners, LR 33:1646 (August 2007).

Robert L. Marier, M.D.  
Executive Director

0708#070

**RULE**

**Department of Health and Hospitals  
Office of the Secretary  
Bureau of Health Services Financing**

**Nursing Facilities—Reimbursement Methodology  
Private Room Conversions (LAC 50:VII.1310)**

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopts §1310 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

**Title 50**

**PUBLIC HEALTH—MEDICAL ASSISTANCE**

**Part VII. Long Term Care Services**

**Subpart 1. Nursing Facilities**

**Chapter 13. Reimbursement Methodology**

**§1310. Additional Payments and Square Footage**

**Adjustments for Private Room Conversion**

A. 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.

**B. Qualifying Facilities**

1. 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 revised property insurance pass-through, all of the following conditions must be met.

a. The nursing facility must convert one or more semi-private rooms to private rooms on or after September 1, 2007.

b. The converted private room(s) must be occupied by a Medicaid resident(s) to receive the \$5 per diem payment.

c. The nursing facility must surrender their bed licenses equal to the number of converted private rooms.

d. The nursing facility must submit the following information to the department within 30 days of the private room conversion:

i. the number of rooms converted from semi-private to private;

ii. the revised bed license;

iii. a resident listing by payer type for the converted private rooms; and

iv. the date of the conversions.

C. The additional \$5 per diem payment determination will be as follows.

1. An additional \$5 will be added to the nursing facility's case-mix rate for each Medicaid resident day in a converted private room.

2. The payment will begin the first day of the following calendar quarter, after the facility meets all of the qualifying criteria in §1310.B.1.

3. 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.

D. The revised fair rental value per diem will be calculated as follows.

1. 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.

2. After a qualifying private room conversion, the allowable square footage per bed used in §1305.D.3.b. will be determined as follows.

a. 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.

b. Square Footage Changes to Existing Buildings. If a change in total nursing square footage occurs in a building existing on the effective date of this rule and that change is concurrent or subsequent to a private room conversion, the allowable square footage will be determined in accordance with §1305.D.3.b.i as if the private room conversion did not occur.

c. Square Footage Changes Due to New Buildings. Replacement buildings constructed or first occupied after the effective date of this rule will have their allowable square footage calculated in accordance with §1305.D.3.b.i.

3. 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 70 percent of the revised annual bed days available after the change in licensed beds.

4. A revised fair rental value per diem will be calculated under §1305.D.3.b. using the allowable square footage according to §1310.D.2, remaining licensed beds, and the revised minimum occupancy calculation.

5. 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 §1310.B.1.

E. Reporting

1. 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.

2. The department may also require an alternate billing procedure for providers to receive the additional \$5 private room rate.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 33:1646 (August 2007).

Implementation of the provisions of this Rule shall be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Frederick P. Cerise, M.D., M.P.H.  
Secretary

0708#090

**RULE**

**Department of Health and Hospitals  
Office of the Secretary**

**Office for Citizens with Developmental Disabilities**

**Home and Community-Based Services Waivers  
New Opportunities Waiver**

**Service Cap Increase and Clarification of Services  
(LAC 50:XXI.13701 and Chapters 139-143)**

The Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental

Disabilities amends LAC 50:XXI.13701 and Chapters 139-143 under the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

**Title 50**

**PUBLIC HEALTH—MEDICAL ASSISTANCE  
Part XXI. Home and Community Based Services  
Waivers**

**Subpart 11. New Opportunities Waiver**

**Chapter 137. General Provisions**

**§13701. Introduction**

A. ...

B. All NOW services are accessed through the case management agency of the recipient's choice. All services must be prior authorized and delivered in accordance with the approved comprehensive plan of care (CPOC). The CPOC shall be developed using a person-centered process coordinated by the individual's case manager.

C. Providers must maintain adequate documentation to support service delivery and compliance with the approved plan of care and will provide said documentation at the request of the department.

D. - F. ...

G. Providers shall follow the regulations and requirements as specified in the NOW provider manual.

H. Home and community-based services shall not be reimbursed while the recipient is a patient in an inpatient facility.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Community Supports and Services, LR 30:1201 (June 2004), amended by the Department of Health and Hospitals, Office of the Secretary, Office for Citizens with Developmental Disabilities, LR 33:1647 (August 2007).

**Chapter 139. Covered Services**

**§13901. Individualized and Family Support Services**

A. Individualized and Family Support (IFS) services are direct support and assistance services provided in the home or the community that allow the recipient to achieve and/or maintain increased independence, productivity, enhanced family functioning and inclusion in the community or for the relief of the primary caregiver. Transportation is included in the reimbursement for these services. Reimbursement for these services includes the development of a service plan for the provision of these services, based on the approved CPOC.

1. ...

a. Additional hours of IFS day services beyond the 16 hours can be approved based on documented need, which can include medical or behavioral and specified in the approved CPOC.

2. - 2.e. ...

B. IFS services may be shared by up to three waiver recipients who may or may not live together and who have a common direct service provider agency. Waiver recipients may share IFS services staff when agreed to by the recipients and health and welfare can be assured for each individual. The decision to share staff must be reflected on the CPOC and based on an individual-by-individual determination.

**JUNE 20, 2008**  
**NURSING FACILITY**  
**BED BUY-BACK**  
**PROGRAM**

C. Designated procedures in the following dental services categories are excluded from the rate increase. The reimbursement fees for these procedures shall continue to be the fee on file in the EPSDT Dental Program Fee Schedule as of October 31, 2007:

1. diagnostic services;
2. preventive services;
3. restorative services;
4. endodontic services;
5. periodontic services;
6. removable and fixed prosthodontic services;
7. oral and maxillofacial surgery services;
8. orthodontic services; and
9. adjunctive general services.
- 10.-12. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 33:1138 (June 2007), amended LR 34:1032 (June 2008).

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) if it is determined that submission for review and approval is required.

Alan Levine  
Secretary

0806#060

#### **RULE**

### **Department of Health and Hospitals Office of the Secretary Bureau of Health Services Financing**

Federally Qualified Health Centers  
Reimbursement Methodology  
Payment for Adjunct Services (LAC 50:XI.10703)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted LAC 50:XI.10703 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:950 et seq.

#### **Title 50**

### **PUBLIC HEALTH—MEDICAL ASSISTANCE**

#### **Part XI. Clinic Services**

#### **Subpart 13. Federally Qualified Health Centers**

#### **Chapter 107. Reimbursement Methodology**

#### **§10703. Alternate Payment Methodology**

A. Effective for dates of service on or after October 20, 2007, the Medicaid Program establishes an alternate payment methodology for adjunct services provided by federally qualified health centers (FQHCs) when these professional services are rendered during evening, weekend or holiday hours. This alternate payment methodology is in addition to the Prospective Payment System methodology established for FQHC services.

1. A payment for adjunct services is not allowed when the encounter is for dental services only.

B. The reimbursement for adjunct services is a flat fee, based on the Current Procedural Terminology (CPT) procedure code, in addition to the reimbursement for the associated office encounter.

C. Reimbursement is limited to services rendered between the hours of 5 p.m. and 8 a.m. Monday through Friday, on weekends and state legal holidays. Documentation relative to this reimbursement must include the time that the services were rendered.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1033 (June 2008).

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) if it is determined that submission for review and approval is required.

Alan Levine  
Secretary

0806#067

#### **RULE**

### **Department of Health and Hospitals Office of the Secretary Bureau of Health Services Financing**

Nursing Facilities—Reimbursement Methodology  
Fair Rental Value, Property Tax and  
Property Insurance Incentive Payments  
(LAC 50:VII.1312)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has amended LAC 50:VII.1312 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

#### **Title 50**

### **PUBLIC HEALTH—MEDICAL ASSISTANCE**

#### **Part VII. Long Term Care Services**

#### **Subpart 1. Nursing Facilities**

#### **Chapter 13. Reimbursement**

#### **§1312. Fair Rental Value, Property Tax and Property Insurance Incentive Payments to Buyers of Nursing Facilities**

A. 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.

B. Qualifying Buyer(s). In order for the buying facility to qualify for the incentive payments described in this Section, the following conditions must be met.

1. Buyer(s) must purchase and close a Medicaid-certified nursing facility within 90 days after the legal transfer of ownership from the seller to buyer(s).

2. After closing the facility, all buyer(s) must permanently surrender their interest in the seller's bed license and the Facility Need Review bed approvals to the state.

3. The buyer(s) must be a 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 the new owner of the nursing facility continues participation in the Medicaid Program as a Medicaid-certified nursing facility.

a. Repealed.

4. The buyer(s) must provide the following documentation to the secretary of the department, in writing, within 30 days after the legal transfer of ownership:

a. a list of all buyer(s);

b. a list of all seller(s);

c. the date of the legal transfer of ownership;

d. each buyer's percentage share of the purchased facility; and

e. each buyer's current nursing facility resident listing and total occupancy calculations as of the date of the legal transfer of ownership.

5. The buyer(s) must provide the following documentation to the secretary of the department, in writing, within 110 days after the legal transfer of ownership:

a. 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;

b. the date that the seller's facility was officially closed and no longer operating as a nursing facility.

C. Incentive Calculation. The total annual Medicaid incentive payment for each transaction will be based on the number of beds surrendered from the closed facility and the cumulative percentage increase in occupancy for all buyers involved in the purchase.

1. Beds surrendered will be based on the licensed beds surrendered for the closed facility. The number of beds surrendered will determine the base capital amount used in the incentive payment calculation as follows.

a. Under 115 beds surrendered will result in a base capital amount of \$303,216.

b. 115 through 144 beds surrendered will result in a base capital amount of \$424,473.

c. 145 beds or more surrendered will result in a base capital amount of \$597,591.

2. 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 as required by §1312.B.4.e and the reported increase in total residents received from the seller as required by §1312.B.5.a.

a. Cumulative occupancy increases for all buyers will determine the percentage of the base capital amount used in the incentive payment calculation as follows:

i. less than 5.00 percent will result in 67 percent of the base capital amount;

ii. 5.00 percent through 9.99 percent will result in 78 percent of the base capital amount;

iii. 10.00 percent through 14.99 percent will result in 89 percent of the base capital amount;

iv. 15.00 percent and up will result in 100 percent of the base capital amount.

3. 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 accordance with §1312.B.4.d. The result will be each buyer's total annual Medicaid incentive payment for five years.

a. Repealed.

b. Repealed.

c. Repealed.

4. Base Capital Amount Updates. On July 1 of each year, the base capital amounts (as defined in §1312.C.1) 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.

D. 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 as required by §1312.B.5.a. The re-base will be retroactive to the date of closure of the purchased facility. The calculation will be as follows.

1. Prior to application of the minimum occupancy calculation, the actual number of total resident days used in the calculation of each buyer's current fair rental value per diem as described in §1305.D.3.b.iii will be increased by the number of residents the buyer reported under §1312.B.5.a 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 as described under §1305.D.4.a will be increased by the number of residents the buyer reported under §1312.B.5.a 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 §1305.B, includes a full 12 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.

E. Payments

1. 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 (20 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 as defined under §1312.C.3 divided by annual Medicaid days. Annual Medicaid days will be equal to Medicaid residents transferred from the seller facility, as determined under §1312.B.5.a, multiplied by total current rate year days plus the buyer's annualized Medicaid days from the most recent base year cost report. If the most recent base year cost report includes or overlaps the period of the transfer, an adjustment will be made to avoid including the transferred days twice.

2. 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).

3. The incentive per diems, the revised fair rental value per diem, and revised property tax and insurance per diem will be updated at every case-mix rebase effective date.

4. The incentive payments when combined with all other Medicaid nursing facility payments shall not exceed the Medicare upper payment limit.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 33:1349 (July 2007), amended LR 34:1033 (June 2008).

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) if it is determined that submission for review and approval is required.

Alan Levine  
Secretary

0806#064

## RULE

### Department of Health and Hospitals Office of the Secretary Bureau of Health Services Financing

#### Professional Services Program—Adult Immunizations (LAC 50:IX.Chapters 83-87)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted LAC 50:IX.Chapters 83-87 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

#### Title 50

### PUBLIC HEALTH—MEDICAL ASSISTANCE

#### Part IX. Professional Services Program

##### Subpart 7. Immunizations

#### Chapter 83. Children's Immunizations (Reserved)

#### Chapter 85. Adult Immunizations

##### §8501. General Provisions

A. Effective October 1, 2007, the department shall provide Medicaid coverage for certain immunizations administered by enrolled Medicaid providers to adult

recipients, age 21 or older. Adult immunizations shall be covered for the following diseases:

1. influenza;
2. pneumococcal; and
3. human papillomavirus (HPV).

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1035 (June 2008).

##### §8503. Coverage Restrictions

A. HPV Immunizations. Immunizations for HPV are restricted to female recipients from age 21 through 26 years old.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1035 (June 2008).

## Chapter 87. Reimbursement

### §8701. Reimbursement Methodology

A. Adult Immunizations. Providers shall be reimbursed according to the established fee schedule for the vaccine and the administration of the vaccine.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1035 (June 2008).

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) if it is determined that submission for review and approval is required.

Alan Levine  
Secretary

0806#065

## RULE

### Department of Health and Hospitals Office of the Secretary Bureau of Health Services Financing

#### Professional Services Program Physicians Services—Payment for Adjunct Services (LAC 50:IX.15121)

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing has adopted LAC 50:IX.15121 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

#### Title 50

### PUBLIC HEALTH—MEDICAL ASSISTANCE

#### Part IX. Professional Services Program

##### Subpart 15. Reimbursement

#### Chapter 151. Reimbursement Methodology

##### §15121. Payment for Adjunct Services

A. Effective for dates of service on or after October 20, 2007, the Medicaid Program shall provide reimbursement

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reduced by 3.5 percent of the fee amounts on file as of January 31, 2009.

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

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:1091 (May 2005), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:

Implementation of the provisions of this Rule is contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Interested persons may submit written comments to Jerry Phillips, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Alan Levine  
Secretary

0902#007

## **DECLARATION OF EMERGENCY**

### **Department of Health and Hospitals Bureau of Health Services Financing**

#### **Nursing Facilities—Leave of Absence Days Reimbursement Reduction (LAC 50:VII.1321)**

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:VII.1321 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act and as directed by Act 19 of the 2008 Regular Session of the Louisiana Legislature which states: "The secretary shall, subject to the review and approval of the Joint Legislative Committee on the Budget, implement reductions in the Medicaid program as necessary to control expenditures to the level appropriated in this Schedule. Notwithstanding any law to the contrary, the secretary is hereby directed to utilize various cost-containment measures to accomplish these reductions, including but not limited to precertification, preadmission screening, diversion, fraud control, utilization review and management, prior authorization, service limitations and other measures as allowed by federal law." This Emergency Rule is promulgated in accordance with the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing promulgated a Rule that amended the provisions governing reimbursement to nursing facilities for hospital leave of absence days (*Louisiana Register*, Volume 27, Number 1). Effective for dates of service on or after July 1, 2008, the reimbursement paid to nursing facilities was increased in accordance with the reimbursement methodology established in the August 20, 2002 Rule (*Louisiana Register*, Volume 28, Number 8). As a result of a budgetary shortfall, the bureau has determined

that it is necessary to reduce the reimbursement paid to nursing facilities for leave of absence days.

This action is necessary to avoid a budget deficit in the medical assistance programs. Taking into consideration the reduction in per diem rates in state fiscal year 2009 for hospital and home leave of absence days based on occupancy rates, the department has carefully reviewed the proposed rates and is satisfied that they are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that non-state nursing facility services under the state plan are available at least to the extent that they are available to the general population in the state. It is estimated that implementation of this Emergency Rule will reduce expenditures in the Medicaid Program by approximately \$1,721,897 for state fiscal year 2008-2009.

Effective February 20, 2009, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for nursing facility leave of absence days.

## **Title 50**

### **PUBLIC HEALTH—MEDICAL ASSISTANCE**

#### **Part VII. Long Term Care Services**

##### **Subpart 1. Nursing Facilities**

#### **Chapter 13. Reimbursement**

##### **§1321. Leave of Absence Days**

A. For each Medicaid recipient, nursing facilities shall be reimbursed for up to seven hospital leave of absence days per occurrence and 15 home leave of absence days per year.

B. The reimbursement for hospital leave of absence days is 75 percent of the applicable per diem rate.

C. Nursing facilities with occupancy rates under 90 percent. Effective for dates of service on or after February 20, 2009, reimbursement for hospital and home leave of absence days will be reduced to 10 percent of the applicable per diem rate in addition to the nursing facility provider fee.

D. Nursing facilities with occupancy rates equal to 90 percent or greater. Effective for dates of service on or after February 20, 2009, the reimbursement paid for home leave of absence days will be reduced to 90 percent of the applicable per diem rate, which includes the nursing facility provider fee.

1. The reimbursement for hospital leave of absence days shall continue to be 75 percent of the applicable per diem rate, which includes the nursing facility provider fee.

E. Occupancy percentages will be determined from the average annual occupancy rate as reflected in the Louisiana Inventory of Nursing Home Bed Utilization Report published from the period six months prior to the beginning of the current rate quarter. Occupancy percentages will be updated quarterly when new rates are loaded and shall be in effect for the entire quarter.

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

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:

Implementation of the provisions of this Rule is contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Interested persons may submit written comments to Jerry Phillips, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for

responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Alan Levine  
Secretary

0902#008

## DECLARATION OF EMERGENCY

### Department of Health and Hospitals Bureau of Health Services Financing

#### Outpatient Hospital Services—Private Hospitals Reimbursement Reduction (LAC 50:V.5313, 5513, 5713, 5913 and 6115)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:V.5313, 5513, 5713, 5913 and adopts §6115 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act and as directed by Act 19 of the 2008 Regular Session of the Louisiana Legislature which states: "The secretary shall, subject to the review and approval of the Joint Legislative Committee on the Budget, implement reductions in the Medicaid program as necessary to control expenditures to the level appropriated in this Schedule. Notwithstanding any law to the contrary, the secretary is hereby directed to utilize various cost-containment measures to accomplish these reductions, including but not limited to precertification, preadmission screening, diversion, fraud control, utilization review and management, prior authorization, service limitations and other measures as allowed by federal law." This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Bureau of Health Services Financing adopted a Rule which established the reimbursement methodology for outpatient hospital services (*Louisiana Register*, Volume 22, Number 1). In compliance with the directives of Act 17 of the 2006 Regular Session of the Louisiana Legislature, the bureau amended the provisions governing the reimbursement methodology for outpatient hospital services to increase the reimbursement paid to private (non-state) acute care hospitals for cost-based outpatient services (*Louisiana Register*, Volume 33, Number 2). As a result of a budgetary shortfall, the bureau has determined that it is necessary to reduce the reimbursement paid to non-rural, non-state hospitals for outpatient services by 3.5 percent. This action is necessary to avoid a budget deficit in the medical assistance programs.

Taking into consideration the 3.5 percent reduction in outpatient hospital rates in state fiscal year 2009, the department has carefully reviewed the proposed rates and is satisfied that they are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that private (non-state) outpatient hospital services under the state plan are available at least to the extent that they are available to the general population in the state. It is estimated that implementation of this Emergency

Rule will reduce expenditures in the Medicaid Program by approximately \$913,312 for state fiscal year 2008-2009.

Effective February 20, 2009, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for certain outpatient hospital services to reduce the reimbursement rates.

## Title 50

### PUBLIC HEALTH—MEDICAL ASSISTANCE

#### Part V. Hospitals

##### Subpart 5. Outpatient Hospitals

#### Chapter 53. Outpatient Surgery

##### Subchapter B. Reimbursement Methodology

#### §5313. Non-Rural, Non-State Hospitals

A. Effective for dates of service on or after February 20, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient surgery shall be reduced by 3.5 percent of the fee schedule on file as of February 19, 2009.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Service Financing, LR 35:

#### Chapter 55. Clinic Services

##### Subchapter B. Reimbursement Methodology

#### §5513. Non-Rural, Non-State Hospitals

A. Effective for dates of service on or after February 20, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient clinic services shall be reduced by 3.5 percent of the fee schedule on file as of February 19, 2009.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Service Financing, LR 35:

#### Chapter 57. Laboratory Services

##### Subchapter B. Reimbursement Methodology

#### §5713. Non-Rural, Non-State Hospitals

A. Effective for dates of service on or after February 20, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient laboratory services shall be reduced by 3.5 percent of the fee schedule on file as of February 19, 2009.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Service Financing, LR 35:

#### Chapter 59. Rehabilitation Services

##### Subchapter B. Reimbursement Methodology

#### §5913. Non-Rural, Non-State Hospitals

A. Effective for dates of service on or after February 20, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient rehabilitation services shall be reduced by 3.5 percent of the fee schedule on file as of February 19, 2009.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Service Financing, LR 35:

#### Chapter 61. Other Outpatient Hospital Services

##### Subchapter B. Reimbursement Methodology

#### §6115. Non-Rural, Non-State Hospitals

A. Effective for dates of service on or after February 20, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient hospital services other than clinical

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B. Guidelines indicated in the pertinent CPT manual are to be followed when billing for these services unless specifically directed otherwise by the department.

C. Limitations on select services are indicated on the published fee schedules and/or in provider manuals.

D. Reimbursement of radiology services shall be the lower of billed charges or the fee on file, minus the amount which any third party coverage would pay.

E. Effective for dates of service on or after February 26, 2009, the reimbursement rates for radiology services shall be reduced by 3.5 percent of the fee amounts on file as of February 25, 2009.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153, R.S. 49:1008(A), P.L. 98-369, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 35:

#### **§4335. Portable Radiology Services**

A. Providers should use the most appropriate Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) code representing the service performed when submitting claims to Medicaid.

B. Reimbursement of portable radiology services shall be the lower of billed charges or the fee on file, minus the amount which any third party coverage would pay.

C. Effective for dates of service on or after February 26, 2009, the reimbursement rates for portable radiology services shall be reduced by 3.5 percent of the fee amounts on file as of February 25, 2009.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 30:1026 (May 2004), amended LR 35:

#### **§4337. Radiation Therapy Centers**

A. Effective for dates of service on or after February 26, 2009, the reimbursement rates for laboratory and radiology services provided by radiation therapy centers shall be reduced by 3.5 percent of the fee amounts on file as of February 25, 2009.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:

Implementation of the provisions of this Rule is contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Interested persons may submit written comments to Jerry Phillips, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Alan Levine  
Secretary

0903#008

## **DECLARATION OF EMERGENCY**

### **Department of Health and Hospitals Bureau of Health Services Financing**

#### **Nursing Facilities—Leave of Absence Days Reimbursement Rate Adjustment (LAC 50:VII.1321)**

The Department of Health and Hospitals, Bureau of Health Services Financing proposes to adopt LAC 50:VII.1321 in the Medical Assistance Program as authorized by R.S. 36:254. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing promulgated a Rule that amended the provisions governing reimbursement to nursing facilities for hospital leave of absence days (*Louisiana Register*, Volume 27, Number 1). Effective for dates of service on or after July 1, 2008, the reimbursement paid to nursing facilities was increased in accordance with the reimbursement methodology established in the August 20, 2002 Rule (*Louisiana Register*, Volume 28, Number 8). As a result of a budgetary shortfall, the bureau promulgated an Emergency Rule to reduce the reimbursement paid to nursing facilities for leave of absence days (*Louisiana Register*, Volume 35, Number 3). The bureau now proposes to amend the February 20, 2009 Emergency Rule to adjust the reimbursement for hospital leave of absence days.

This action is being taken to align the reimbursement methodology for hospital and home leave of absence days for nursing facilities with occupancy equal to or greater than 90 percent. It is estimated that implementation of this Emergency rule will increase expenditures in the Medicaid Program by approximately \$102,344 for state fiscal year 2008-2009.

Effective March 1, 2009, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for nursing facility leave of absence days.

#### **Title 50**

### **PUBLIC HEALTH—MEDICAL ASSISTANCE**

#### **Part VII. Long Term Care Services**

##### **Subpart 1. Nursing Facilities**

#### **Chapter 13. Reimbursement**

##### **§1321. Leave of Absence Days**

A. For each Medicaid recipient, nursing facilities shall be reimbursed for up to seven hospital leave of absence days per occurrence and 15 home leave of absence days per year.

B. The reimbursement for hospital leave of absence days is 75 percent of the applicable per diem rate.

C. Nursing facilities with occupancy rates less than 90 percent. Effective for dates of service on or after February 20, 2009, reimbursement for hospital and home leave of absence days will be reduced to 10 percent of the applicable per diem rate in addition to the nursing facility provider fee.

D. Nursing facilities with occupancy rates equal to or greater than 90 percent. Effective for dates of service on or after February 20, 2009, the reimbursement paid for home leave of absence days will be reduced to 90 percent of the applicable per diem rate, which includes the nursing facility provider fee.

E. Effective for dates of service on or after March 1, 2009, the reimbursement for hospital leave of absence days shall be 90 percent of the applicable per diem rate, which includes the nursing facility provider fee.

F. Occupancy percentages will be determined from the average annual occupancy rate as reflected in the Louisiana Inventory of Nursing Home Bed Utilization Report published from the period six months prior to the beginning of the current rate quarter. Occupancy percentages will be updated quarterly when new rates are loaded and shall be in effect for the entire quarter.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:

Implementation of the provisions of this Rule is contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Interested persons may submit written comments to Jerry Phillips, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Alan Levine  
Secretary

0903#005

## DECLARATION OF EMERGENCY

**Department of Health and Hospitals  
Bureau of Health Services Financing  
and  
Office of Aging and Adult Services**

Personal Care Services—Long Term  
(LAC 50:XV.12901, 12909, 12915)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amends LAC 50:XV.12901, 12909 and 12915 under the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

Pursuant to the Deficit Reduction Act of 2005, the Department of Health and Hospitals, Office of Aging and Adult Services amended the provisions governing long-term personal care services to implement a pilot program called the Louisiana Personal Options Program (La POP) which allows Medicaid recipients to direct and manage their own personal care services (*Louisiana Register*, Volume 34, Number 12).

In recognition of escalating program expenditures, Senate Resolution 180 and House Resolution 190 of the 2008 Regular Session of the Louisiana Legislature directed the Department to develop and implement cost control mechanisms to provide the most cost-effective means of financing for the Long-Term Personal Care Services (LT-PCS) Program. In compliance with these legislative directives, the Department of Health and Hospitals, Office for Aging and Adult Services promulgated an Emergency Rule to amend the provisions governing LT-PCS to: 1) implement uniform needs-based assessments for authorizing service units; 2) reduce the limit on LT-PCS service hours; and 3) mandate that providers must show cause for refusing to serve clients (*Louisiana Register*, Volume 35, Number 1). The department now proposes to amend the February 1, 2009 Emergency Rule to incorporate provisions governing an allocation of weekly service hours in the LT-PCS Program. This action is being taken to avoid a future budget deficit due to the escalating costs associated with LT-PCS. In addition, it is anticipated that this action will promote the health and well-being of recipients through the accurate identification and evaluation of the supports needed to safely maintain these individuals in their homes and communities.

Effective March 20, 2009, the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services amends the provisions of the February 1, 2009 Emergency Rule governing Long Term-Personal Care Services.

### Title 50

## PUBLIC HEALTH—MEDICAL ASSISTANCE

### Part XV. Services for Special Populations

#### Subpart 9. Personal Care Services

#### Chapter 129. Long Term Care

#### §12901. General Provisions

A. ...

B. Each long-term personal care services (LT-PCS) applicant shall be assessed using a uniform assessment tool called the Minimum Data Set-Home Care (MDS-HC). The MDS-HC is designed to verify that an individual meets a nursing facility level of care and to identify his/her need for support in conducting activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The MDS-HC assessment generates a score that assigns the individual to a Resource Utilization Group (RUG-III/HC).

C. The following seven primary RUG-III/HC categories and subcategories will be utilized to determine the assistance needed for various ADLs and IADLs.

1. Special Rehabilitation. Individuals in this category have had at least 120 minutes of rehabilitation therapy (physical, occupational or speech) within the seven days prior to their MDS-HC assessment.

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WAGE ADD-ON/  
RATE REDUCTION/  
UPDATED REBASE  
LANGUAGE**

## DECLARATION OF EMERGENCY

### Department of Health and Hospitals Bureau of Health Services Financing

#### Nursing Facilities—Reimbursement Methodology Rate Determination (LAC 50:VII.1305)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:VII.1305 in the Medical Assistance Program as authorized by R.S. 46:2742.B.7, Senate Bill 247 of the 2009 Regular Session of the Louisiana Legislature and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R. S. 49:953(B)(1), et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amended the provisions governing the reimbursement methodology for nursing facilities by increasing the reimbursement paid to providers to implement a wage enhancement for direct care staff employed with the nursing facility (*Louisiana Register*, Volume 33, Number 10).

Senate Bill (SB) 247 of the 2009 Regular Session of the Louisiana Legislature directed the Department to establish provisions which provide for the periodic rebasing of nursing facility rates utilizing the most current cost reports. In compliance with SB 247, the department proposes to amend the provisions governing the reimbursement methodology for nursing facilities to implement periodic rebasing of the nursing facility rates. This action is being taken to promote the health and well-being of nursing facility residents by assuring that nursing facility providers receive reimbursement commensurate with actual cost of providing care to assure their continued participation in the Medicaid Program. It is estimated that implementation of this Emergency Rule will increase expenditures in the Medicaid Program by approximately \$102,797,774 for state fiscal year 2009-10.

Effective July 3, 2009, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for nursing facilities to implement periodic rebasing of the nursing facility rates.

#### Title 50

### PUBLIC HEALTH—MEDICAL ASSISTANCE

#### Part VII. Long Term Care Services

##### Subpart 1. Nursing Facilities

#### Chapter 13. Reimbursement

#### §1305. Rate Determination

A. ...

B. 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.

1. Effective July 3, 2009, and at a minimum, 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. The department, at its discretion, may rebase at an earlier time.

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

C. - E. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1791 (August 2002), amended LR 31:1596 (July 2005), LR 32:2263 (December 2006), LR 33:2203 (October 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Jerry Phillips, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Alan Levine  
Secretary

0907#011

## DECLARATION OF EMERGENCY

### Department of Health and Hospitals Bureau of Health Services Financing

#### Nursing Facilities—Reimbursement Rate Reduction (LAC 50:VII.1305 and 1309)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:VII.1305 and §1309 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. In the event the department projects that expenditures in the Medical Vendor Program may exceed the funding allocated in the General Appropriations Act, the secretary shall, subject to the review and approval of the Joint Legislative Committee on the Budget, implement reductions in the Medicaid Program as necessary to control expenditures to the level of funding appropriated by the legislature. Notwithstanding any law to the contrary, the secretary may utilize various cost-containment measures to accomplish these reductions, including but not limited to precertification, preadmission screening, diversion, fraud control, utilization review and management, prior authorization, service limitations and other measures as allowed by federal law. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R. S. 49:953(B)(1), et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amended the provisions governing the reimbursement methodology for

nursing facilities by increasing the reimbursement paid to providers to implement a wage enhancement for direct care staff employed with the nursing facility (*Louisiana Register*, Volume 33, Number 10).

In anticipation of projected expenditures in the Medical Vendor Program exceeding the funding allocated in the General Appropriations Act, the department has determined that it is necessary to reduce the reimbursement rates paid to non-state nursing facilities. This action is being taken in order to avoid a budget deficit in the medical assistance programs.

Taking the 7.56 percent reduction in per diem rates in state fiscal year 2010 into consideration, the department has carefully reviewed the proposed rates and is satisfied that they are consistent with efficiency, economy and quality of care and are sufficient to enlist enough providers so that non-state nursing facility services under the State Plan are available at least to the extent that they are available to the general population in the state. It is estimated that implementation of this Emergency rule will reduce expenditures in the Medicaid Program by approximately \$58,055,047 for state fiscal year 2009-2010.

Effective July 3, 2009, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for non-state nursing facilities to reduce the reimbursement rates.

#### **Title 50**

### **PUBLIC HEALTH—MEDICAL ASSISTANCE**

#### **Part VII. Long Term Care Services**

##### **Subpart 1. Nursing Facilities**

#### **Chapter 13. Reimbursement**

##### **§1305. Rate Determination**

A. - D.1.h.Example. ...

i. For dates of service on or after July 3, 2009, the facility-specific direct care rate will be adjusted in order to reduce the wage enhancement from \$4.70 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. It is the intent that this wage enhancement be paid to the direct care staff.

i. Effective with the next rebase, on or after July 1, 2010, the wage enhancement will be eliminated.

D.2. - 4.b. ...

5. Adjustment to the Rate. Adjustments to the Medicaid daily rate may be made when changes occur that will eventually be recognized in updated cost report data (such as a change in the minimum wage, a change in FICA or a utility rate change). These adjustments would be effective until the next rebasing of cost report data or until such time as the cost reports fully reflect the change.

6. Budget Shortfall. 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. Without changing the parameters established in these provisions, this category shall reduce the statewide average Medicaid rate by reducing the reimbursement rate paid to each nursing facility using an equal amount per patient day.

a. Effective for dates of service on or after July 3, 2009, the reimbursement paid to non-state nursing facilities

shall be reduced by 7.56 percent of the per diem rate on file as of July 2, 2009.

E. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1791 (August 2002), LR 31:1596 (July 2005), LR 32:2263 (December 2006), LR 33:2203 (October 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:

#### **§1309. State-Owned or Operated and Non-State, Government-Owned or Operated Facilities**

A. - B.2. ...

C. Effective for dates of service on and after July 3, 2009, the reimbursement paid to non-state, government-owned and operated nursing facilities shall be reduced by 7.56 percent of the per diem rate on file as of July 2, 2009.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1793 (August 2002), amended LR 30:53 (January 2004), LR 31:1596 (July 2005), LR 32:2265 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:

Implementation of the provisions of this Rule is contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Interested persons may submit written comments to Jerry Phillips, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Alan Levine  
Secretary

0907#010

### **DECLARATION OF EMERGENCY**

#### **Department of Health and Hospitals Bureau of Health Services Financing**

Outpatient Hospital Services  
Non-Rural, Non-State Hospitals  
Supplemental Payments  
(LAC 50:V.5315, 5515, 5715, 5915 and 6117)

The Department of Health and Hospitals, Bureau of Health Services Financing adopts LAC 50:V.5315, §5515, §5715, §5915 and §6117 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1) et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing adopted a Rule which established the reimbursement methodology for

**SEPTEMBER 20, 2009  
NURSING FACILITY  
LEAVE OF ABSENCE  
REIMBURSEMENT  
RATES AND MAX  
ALLOWED DAYS**

Health and Human Services, Centers for Medicare and Medicaid Services (CMS) if it is determined that submission to CMS for review and approval is required.

Alan Levine  
Secretary

0909#088

#### **RULE**

### **Department of Health and Hospitals Bureau of Health Services Financing and Office of Aging and Adult Services**

Medicaid Eligibility—Long-Term Care Insurance  
Resource Disregard (LAC 50:III.10705)

The Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services has adopted LAC 50:III.10705 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

#### **Title 50**

### **PUBLIC HEALTH—MEDICAL ASSISTANCE**

#### **Part III. Eligibility**

#### **Subpart 5. Financial Eligibility**

#### **Chapter 107. Resources**

#### **§10705. Resource Disregards**

A. In compliance with the Deficit Reduction Act, individuals who are insured under a long-term care insurance policy that meets the requirements of a "qualified state long-term care insurance partnership" policy shall receive a disregard of resources equal to the amount paid under the insurance policy.

1. The Medicaid Program shall accept the certification of the Louisiana Commissioner of Insurance that the long-term care policy meets the requirements of a "qualified long-term care insurance partnership" policy.

B. The resource disregard is determined on a 1:1 ratio. For each \$1 of a qualifying long-term care insurance partnership policy benefit amount paid, \$1 of countable resources is disregarded or excluded during the eligibility determination process.

1. The disregard is permitted at the time a recipient begins receiving benefits from a qualifying long-term care insurance partnership policy.

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

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 35:1899 (September 2009).

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) if it is determined that submission to CMS for review and approval is required.

Alan Levine  
Secretary

0909#088

#### **RULE**

### **Department of Health and Hospitals Bureau of Health Services Financing**

Mental Health Rehabilitation  
Program Reimbursement Rate Reduction  
(LAC 50:XV.901)

The Department of Health and Hospitals, Bureau of Health Services Financing has amended LAC 50:XV.901 in the Medical Assistance Program as authorized by R.S. 36:254, pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950, et seq.

#### **Title 50**

### **PUBLIC HEALTH—MEDICAL ASSISTANCE**

#### **Part XV. Services for Special Populations**

#### **Subpart 1. Mental Health Rehabilitation**

#### **Chapter 9. Reimbursement**

#### **§901. Reimbursement Methodology**

A. - B. ...

C. Effective for dates of service on or after February 1, 2009, the reimbursement rates for MHR services shall be reduced by 3.5 percent of the fee amounts on file as of January 31, 2009.

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

**HISTORICAL NOTE:** Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:1091 (May 2005), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1899 (September 2009).

Alan Levine  
Secretary

0909#103

#### **RULE**

### **Department of Health and Hospitals Bureau of Health Services Financing**

Nursing Facilities—Leave of Absence Days  
Reimbursement Reduction (LAC 50:VII.1321)

The Department of Health and Hospitals, Bureau of Health Services Financing has adopted LAC 50:VII.1321 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the Administrative Procedure Act, R. S. 49:950, et seq.

#### **Title 50**

### **PUBLIC HEALTH—MEDICAL ASSISTANCE**

#### **Part VII. Long Term Care Services**

#### **Subpart 1. Nursing Facilities**

#### **Chapter 13. Reimbursement**

#### **§1321. Leave of Absence Days**

A. For each Medicaid recipient, nursing facilities shall be reimbursed for up to seven hospital leave of absence days per occurrence and 15 home leave of absence days per year.

B. The reimbursement for hospital leave of absence days is 75 percent of the applicable per diem rate.

C. Nursing facilities with occupancy rates less than 90 percent. Effective for dates of service on or after February 20, 2009, reimbursement for hospital and home leave of absence days will be reduced to 10 percent of the applicable per diem rate in addition to the nursing facility provider fee.

D. Nursing facilities with occupancy rates equal to or greater than 90 percent. Effective for dates of service on or after February 20, 2009, the reimbursement paid for home leave of absence days will be reduced to 90 percent of the applicable per diem rate, which includes the nursing facility provider fee.

1. Effective for dates of service on or after March 1, 2009, the reimbursement for hospital leave of absence days for nursing facilities with occupancy rates equal to or greater than 90 percent shall be 90 percent of the applicable per diem rate, which includes the nursing facility provider fee.

E. Occupancy percentages will be determined from the average annual occupancy rate as reflected in the Louisiana Inventory of Nursing Home Bed Utilization Report published from the period six months prior to the beginning of the current rate quarter. Occupancy percentages will be updated quarterly when new rates are loaded and shall be in effect for the entire quarter.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1899 (September 2009).

Alan Levine  
Secretary

0909#090

## RULE

### Department of Health and Hospitals Bureau of Health Services Financing

#### Outpatient Hospital Services—Non-Rural, Non-State Hospitals—Reimbursement Rate Reduction (LAC:V.5313, 5513, 5713, 5913 and 6115)

The Department of Health and Hospitals, Bureau of Health Services Financing has adopted LAC 50:V.5313, §§5513, 5713, 5913 and to adopt §6115 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

#### Title 50

#### PUBLIC HEALTH—MEDICAL ASSISTANCE

#### Part V. Hospitals

#### Subpart 5. Outpatient Hospitals

#### Chapter 53. Outpatient Surgery

#### Subchapter B. Reimbursement Methodology

#### §5313. Non-Rural, Non-State Hospitals

A. Effective for dates of service on or after February 20, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient surgery shall be reduced by 3.5 percent of the fee schedule on file as of February 19, 2009.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Service Financing, LR 35:1900 (September 2009).

#### Chapter 55. Clinic Services

#### Subchapter B. Reimbursement Methodology

#### §5513. Non-Rural, Non-State Hospitals

A. Effective for dates of service on or after February 20, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient clinic services shall be reduced by 3.5 percent of the fee schedule on file as of February 19, 2009.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Service Financing, LR 35:1900 (September 2009).

#### Chapter 57. Laboratory Services

#### Subchapter B. Reimbursement Methodology

#### §5713. Non-Rural, Non-State Hospitals

A. Effective for dates of service on or after February 20, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient laboratory services shall be reduced by 3.5 percent of the fee schedule on file as of February 19, 2009.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Service Financing, LR 35:1900 (September 2009).

#### Chapter 59. Rehabilitation Services

#### Subchapter B. Reimbursement Methodology

#### §5913. Non-Rural, Non-State Hospitals

A. Effective for dates of service on or after February 20, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient rehabilitation services provided to recipients over the age of three years shall be reduced by 3.5 percent of the fee schedule on file as of February 19, 2009.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Service Financing, LR 35:1900 (September 2009).

#### Chapter 61. Other Outpatient Hospital Services

#### Subchapter B. Reimbursement Methodology

#### §6115. Non-Rural, Non-State Hospitals

A. Effective for dates of service on or after February 20, 2009, the reimbursement paid to non-rural, non-state hospitals for outpatient hospital services other than clinical diagnostic laboratory services, outpatient surgeries, rehabilitation services and outpatient hospital facility fees shall be reduced by 3.5 percent of the rates effective as of February 19, 2009. Final reimbursement shall be at 83.18 percent of allowable cost through the cost settlement process.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Service Financing, LR 35:1900 (September 2009).

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and

**OCTOBER 20, 2009  
REPEAL OF RATE  
REDUCTION**

D. Individuals determined eligible in this group shall receive coverage of medically necessary health care services provided under the Medicaid State Plan.

1. The assistance unit shall consist of the youth only.

E. Eligibility for the program will continue until the youth reaches age 21 unless the youth:

1. moves out of state;
2. requests closure of the case;
3. is incarcerated; or
4. dies.

F. Application Process. No application is required for this eligibility group. Closure of a foster care case due to the youth reaching age 18 establishes eligibility.

G. Certification Period. The certification period shall begin the month the youth reaches age 18 and will end on the last day of the month in which the youth reaches age 21.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:

Interested persons may submit written comments to Jerry Phillips, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Alan Levine  
Secretary

0910#057

## DECLARATION OF EMERGENCY

### Department of Health and Hospitals Bureau of Health Services Financing

Nursing Facilities  
Reimbursement Methodology  
Rate Determination  
(LAC 50:VII.1305)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:VII.1305 in the Medical Assistance Program as authorized by R.S. 46:2742.B.7, Act 244 of the 2009 Regular Session of the Louisiana Legislature and pursuant to Title XIX of the Social Security Act. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R. S. 49:953(B)(1), et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amended the provisions governing the reimbursement methodology for nursing facilities by increasing the reimbursement paid to providers to implement a wage enhancement for direct care staff employed with the nursing facility (*Louisiana Register*, Volume 33, Number 10).

Act 244 of the 2009 Regular Session of the Louisiana Legislature directed the Department to establish provisions which provide for the periodic rebasing of nursing facility rates utilizing the most current cost reports. In compliance

with Act 244, the department promulgated an Emergency Rule to amend the provisions governing the reimbursement methodology for nursing facilities to implement periodic rebasing of the nursing facility rates (*Louisiana Register*, Volume 35, Number 7). This Emergency Rule is being promulgated to continue the provisions of the July 3, 2009 Emergency Rule. This action is being taken to promote the health and well-being of nursing facility residents by assuring that nursing facility providers receive reimbursement commensurate with actual cost of providing care to assure their continued participation in the Medicaid Program.

Effective November 1, 2009, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for nursing facilities to implement periodic rebasing of the nursing facility rates.

## Title 50

### PUBLIC HEALTH—MEDICAL ASSISTANCE

#### Part VII. Long Term Care Services

##### Subpart 1. Nursing Facilities

#### Chapter 13. Reimbursement

##### §1305. Rate Determination

A. ...

B. 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.

1. Effective July 3, 2009, and at a minimum, 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. The department, at its discretion, may rebase at an earlier time.

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

C. - E. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1791 (August 2002), amended LR 31:1596 (July 2005), LR 32:2263 (December 2006), LR 33:2203 (October 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Interested persons may submit written comments to Jerry Phillips, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Alan Levine  
Secretary

0910#058

## DECLARATION OF EMERGENCY

### Department of Health and Hospitals Bureau of Health Services Financing

#### Nursing Facilities Reimbursement Rate Reduction (LAC 50:VII.1305 and 1309)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:VII.1305 and §1309 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. In the event the department projects that expenditures in the Medical Vendor Program may exceed the funding allocated in the General Appropriations Act, the secretary shall, subject to the review and approval of the Joint Legislative Committee on the Budget, implement reductions in the Medicaid Program as necessary to control expenditures to the level of funding appropriated by the legislature. Notwithstanding any law to the contrary, the secretary may utilize various cost-containment measures to accomplish these reductions, including but not limited to precertification, preadmission screening, diversion, fraud control, utilization review and management, prior authorization, service limitations and other measures as allowed by federal law. This Emergency Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:953(B)(1), et seq., and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

The Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing amended the provisions governing the reimbursement methodology for nursing facilities by increasing the reimbursement paid to providers to implement a wage enhancement for direct care staff employed with the nursing facility (*Louisiana Register*, Volume 33, Number 10).

In anticipation of projected expenditures in the Medical Vendor Program exceeding the funding allocated in the General Appropriations Act, the department promulgated an Emergency Rule to reduce the reimbursement rates paid to non-state nursing facilities (*Louisiana Register*, Volume 35, Number 7). The department now proposes to amend the July 3, 2009 Emergency Rule to repeal the reduction to the per diem rates of non-state nursing facilities. This action is being taken to promote the health and welfare of Medicaid recipients by encouraging the continued participation of non-state nursing facilities in the Medicaid Program.

Effective October 20, 2009, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions of the July 3, 2009 Emergency Rule governing the reimbursement methodology for non-state nursing facilities.

#### Title 50

### PUBLIC HEALTH—MEDICAL ASSISTANCE

#### Part VII. Long Term Care Services

##### Subpart 1. Nursing Facilities

#### Chapter 13. Reimbursement

#### §1305. Rate Determination

A. - D.1.h.Example ...

i. For dates of service on or after July 3, 2009, the facility-specific direct care rate will be adjusted in order to reduce the wage enhancement from \$4.70 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. It is the intent that this wage enhancement be paid to the direct care staff.

i. Effective with the next rebase, on or after July 1, 2010, the wage enhancement will be eliminated.

D.2. - 4.b. ...

5. Adjustment to the Rate. Adjustments to the Medicaid daily rate may be made when changes occur that will eventually be recognized in updated cost report data (such as a change in the minimum wage, a change in FICA or a utility rate change). These adjustments would be effective until the next rebasing of cost report data or until such time as the cost reports fully reflect the change.

6. Budget Shortfall. 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. Without changing the parameters established in these provisions, this category shall reduce the statewide average Medicaid rate by reducing the reimbursement rate paid to each nursing facility using an equal amount per patient day.

a. Repealed.

E. ...

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1791 (August 2002), LR 31:1596 (July 2005), LR 32:2263 (December 2006), LR 33:2203 (October 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:

#### §1309. State-Owned or Operated and Non-State, Government-Owned or Operated Facilities

A. - B.2. ...

C. Repealed.

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

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1793 (August 2002), amended LR 30:53 (January 2004), LR 31:1596 (July 2005), LR 32:2265 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:

Implementation of the provisions of this Rule is contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

Interested persons may submit written comments to Jerry Phillips, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821-9030. He is responsible for responding to inquiries regarding this Emergency Rule. A copy of this Emergency Rule is available for review by interested parties at parish Medicaid offices.

Alan Levine  
Secretary

0910#054