DECLARATION OF EMERGENCY

Department of Health
Bureau of Health Services Financing

Nursing Facilities
Reimbursement Methodology
(LAC 50:II.Chapter 200)

The Department of Health, Bureau of Health Services Financing amends LAC 50:II.Chapter 200 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. 49:962 and shall be in effect for the maximum period allowed under the Act or until adoption of the final Rule, whichever occurs first.

Effective June 30, 2025, the Department of Health, Bureau of Health Services Financing amends the provisions governing reimbursement for Nursing Facilities to revise the language and to replace resource utilization group resident classification system with the patient driven payment model (PDPM). The PDPM shifts the focus from therapy-based payments to a more patient-centered approach that takes into account the individual needs and conditions of residents. This action is being taken to comply with federal requirements.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part II. Nursing Facilities
Subpart 5. Reimbursement

Editor's Note: This Subpart has been moved from LAC 50:VII.Chapter 13 and renumbered.

Chapter 200. Reimbursement Methodology

§20001. General Provisions

A. Definitions

Active Assessment—a resident MDS assessment is considered active when it has been accepted by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). The assessment will remain active until:

a. a subsequent minimum data set (MDS) assessment for the same resident has been accepted by CMS;

b. the maximum number of days (121) for the assessment has been reached;

c. the record has been replaced by a modified assessment;

d. the record has been inactivated; or

e. the resident has been discharged.

* * *

Assessment Reference Date—the last day of the MDS observation period, denoted at MDS item A2300. This date is used to determine the due date and delinquency of assessments.

* * *

Case-Mix Documentation Review (CMDR)—a review of original legal medical record documentation and other documentation as designated by the department in the MDS supportive documentation requirements, supplied by a nursing facility provider to support certain reported values that resulted in a specific PDPM classification on a randomly selected MDS assessment sample. The review of the documentation provided by the nursing facility will result in the PDPM classification being supported or unsupported.

Case-Mix Index (CMI)—a numerical value that describes the resident's resource needs within the groups under the patient driven payment model (PDPM) classification system, prescribed by the department based on the resident's MDS assessments. CMIs will be determined for each nursing facility on a quarterly basis using all residents.

* * *

Delinquent MDS Resident Assessment—an active MDS assessment that is more than 121 days old, as measured by the assessment reference date (ARD) field on the MDS, and an MDS assessment that lacks the MDS item responses necessary to calculate a valid PDPM Health Insurance Prospective Payment System (HIPPS) code.

Department—the Louisiana Department of Health (LDH), and the associated work product of its designated contractors and agents.

* * *

Final Case-Mix Index Report (FCIR)—the final report that reflects the acuity of the residents in the nursing facility during the reporting period.

a. - b. ...

Index Factor—generated pursuant to 42·CFR·413.333.

MDS Supportive Documentation Requirements—the department's publication of the minimum documentation and review standard requirements for the MDS items associated with the PDPM classification system. These requirements shall be maintained by the department and updated and published as necessary.

* * *

Optional State Assessment (OSA)—assessment required by the Medicaid program. Allows nursing facility providers using RUG-III models as the basis for Medicaid payment to do so until the legacy payment model (RUG-III) ends.

* * *

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

a. Effective as of the July 1, 2025, rate setting, for Medicaid program nursing facility case-mix index and reimbursement rate calculation purposes, the following PDPM components will be utilized to calculate the nursing facility provider's total residents average CMI and Medicaid residents average CMI under a blended approach. This is done by using case-mix index weights, effective October 1, 2024, as listed in table 5 from the final SNF PPS payment rule for FY 2025 (CMS-1802-F):

i. physical therapy: 15 percent;

ii. occupational therapy: 15 percent;

iii. speech language pathology: 8 percent;

iv. non-therapy ancillary: 12 percent; and

v. nursing: 50 percent.

Point-In-Time Acuity Measurement System (PIT)—Repealed.

Patient Day—a unit of time, a full 24-hour period, during which a Medicaid beneficiary is receiving care in a hospital or skilled nursing facility.

Preliminary Case-Mix Index Report (PCIR)—the preliminary report that reflects the acuity of the residents in the nursing facility during the reporting period.

a. - b. ...

RUG-III Resident Classification System—the resource utilization group used to classify residents. When a resident is sorted into more than one classification group using RUG-III, the RUG-III group with the greatest CMI will be utilized to calculate the nursing facility provider's total residents average CMI and Medicaid residents average CMI.

a. Effective June 30, 2025, the RUG-III Resident Classification System will no longer be utilized to classify residents except for the purposes of calculating the phase-in as described in §20005.D.4.e.

* * *

Unsupported MDS Resident Assessment—an assessment where one or more data items that are used to classify a resident pursuant to the PDPM classification, resident classification systems are not supported according to the MDS supportive documentation requirements and a different PDPM classification, would result; therefore, the MDS assessment would be considered "unsupported."

B. - C.7. ...

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), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:825 (March 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1522 (September 2016), LR 43:525 (March 2017), LR 43:2187 (November 2017), LR 46:695 (May 2020), LR 46:1684 (December 2020), LR 50:219 (February 2024), LR 51:

20005. Rate Determination
[Formerly LAC 50:VII.1305]

A. - C.6. ...

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. - d. ...

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 reduction in the average Medicaid rate due to a budget reduction implemented by the department. The floor cannot be reduced below 90 percent of the direct care and care related resident-day-weighted median cost. Effective for rate periods coinciding with the phase-in established in §20005.D.4.e, July 1, 2025, through December 31, 2026, the statewide direct care and care-related floor is established at 90 percent of the direct care and care related resident-day-weighted median cost.

D.1.f - D.4.d.v. ...

e. Effective for rate periods beginning July 1, 2025, through December 31, 2026, each applicable nursing facility provider will receive an additional pass-through rate adjustment to allow for a phase-in of the PDPM resident classification system used for determining case-mix indices. The nursing facility provider pass-through rate adjustment will be calculated and applied as follows.

i. For each rate period during the phase-in, the nursing facility provider's direct care and care-related rate components will be calculated in accordance with §20005.D.1 using the PDPM resident classification system to determine the nursing facility cost report period case mix index and nursing facility-wide average case mix index values.

ii. For use in calculating a differential, the nursing facility provider's July 1, 2025, direct care and care-related rate components will also be calculated in accordance with §20005.D.1 using the RUG-III resident classification system to determine the nursing facility cost report period case mix index and nursing facility-wide average case mix index values.

iii. For each rate period during the phase-in, the direct care and care-related rate components differential will be determined by subtracting the direct care and care-related rate components calculated for July 1, 2025, using the RUG-III resident classification system as described in §20005.D.4.e.ii from the direct care and care-related rate components calculated using the PDPM resident classification system for determining the case-mix indices as described in §20005.D.4.e.i.

iv. If the calculated direct care and care-related rate components differential exceeds a positive or negative $5, then a pass-through rate adjustment will be applied to the nursing facility provider's reimbursement rate. The pass-through rate will be applied in an amount equal to the difference between the rate differential total and the ±$5 threshold. This will be done in order to ensure the nursing facility provider's direct care and care-related rate components are not increased or decreased more than $5 as a result of the change to the PDPM resident classification system for determining the case-mix indices.

(a). Should the nursing facility provider, for the rate periods used in calculating the rate differential, receive an adjusted nursing facility-wide average case mix index value due to a CMDR change or other factors, the facility will have its direct care and care-related rate components differential recalculated using the revised case mix index values. The ±$5 rate change threshold will apply to the recalculated differential and associated case mix index values, not the original differential calculation.

v. If a nursing facility provider's calculated direct care and care-related rate components differential does not exceed the ±$5 rate change threshold, then no pass-through rate adjustment will be applied for the applicable rate period.

D.5. - Q.…

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), 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 36:325 (February 2010), repromulgated LR 36:520 (March 2010), amended LR 36:1556 (July 2010), LR 36:1782 (August 2010), LR 36:2566 (November 2010), LR 37:902 (March 2011), LR 37:1174 (April 2011), LR 37:2631 (September 2011), LR 38:1241 (May

2012), LR 39:1286 (May 2013), LR 39:3097, 3097 (November 2013), LR 41:707 (April 2015), LR 41:949 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:82 (January 2017), LR 43:526 (March 2017), LR 46:1684 (December 2020), LR 51:

§20006. Reimbursement Adjustment
[Formerly LAC 50:VII.1306]

A. ...

B. In the event the department is required to implement positive adjustments in the nursing facility program pursuant to Louisiana Constitution Art. VII, §10.14(E)(1), a separate nursing facility add-on shall be created and calculated as follows:

1. Without changing the parameters established in these provisions, if the average Medicaid program rates established annually at each July 1 are below the previous state fiscal year's average Medicaid program rates (simple average of the four quarters), the department shall implement an increase to the average Medicaid rate. This will be done by adding to the reimbursement rate paid to each nursing facility an amount equal to the difference between the July 1 Medicaid program rate and the previous state fiscal year's average Medicaid program rates. The add-on will be paid to each nursing facility using an equal amount per patient day.

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), amended by the Department of Health Bureau of Health Services Financing, LR 51:

§20007. Case-Mix Index Calculation
[Formerly LAC 50:VII.1307]

A. The Resource Utilization Groups-III (RUG-III) Version 5.20, 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 5.20, or its successor, case-mix indices developed by 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.

1. Prior to the July 1, 2025, rate setting, the RUG-III, Version 5.20, 34-group index maximizer model is used as the resident classification system to determine all case-mix indices.

B. Effective as of the July 1, 2025, rate setting, PDPM case-mix groups and case-mix index weights effective October 1, 2024, as listed in table 5 from the final SFY PPS payment rule for FY 2025 (CMS-1802-F) are used as the resident classification system to determine all case-mix indices, using data from the MDS submitted by each facility. PDPM case-mix index weights effective October 1, 2024, developed by CMS, shall be used to adjust the direct care cost component. A hierarchal methodology is used to determine the individual CMIs. A blended approach is used to determine the case-mix indices to adjust the direct care cost component. The percentages used for blended approach are as follows:

1. physical therapy: 15 percent;
2. occupational therapy: 15 percent;
3. speech language pathology: 8 percent;
4. non-therapy ancillary: 12 percent; and
5. nursing: 50 percent.

C. Assessments completed prior to January 1, 2025, that cannot be classified to a PDPM case-mix group, will be excluded from the average case mix index calculations.

D. Assessments completed on or after January 1, 2025, that cannot be classified to a PDPM case-mix group, will be assigned the lowest CMI value relative for each PDPM component.

E. Each resident in the nursing facility with a completed and submitted assessment, shall be assigned a PDPM case-mix groups, based on the following criteria.

1. Prior to the January 1, 2017, rate setting, the RUG-III group, or its successor, is calculated based on the resident's most current assessment, available on the last 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 provider shall be determined four times per year based on the last day of each calendar quarter.

2. Effective as of the January 1, 2017, rate setting, the RUG-III group, PDPM group, will be calculated using each resident MDS assessment transmitted and accepted by CMS that is considered active within a given calendar quarter. These assessments are then translated to the appropriate case mix index. The individual resident case mix indices are then weighted based on the number of calendar days each assessment is active within a given calendar quarter. Using the individual resident case mix indices, the calendar day weighted average nursing facility-wide case mix index is calculated using all residents regardless of payer type. The calendar day weighted nursing facility-wide average case mix index for each Medicaid nursing facility shall be determined four times per year.

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), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:826 (March 2012), LR 43:527 (March 2017), amended by the Department of Health Bureau of Health Services Financing, LR 51:

§20013. Case-Mix Documentation Reviews and Case-Mix Index Reports
[Formerly LAC 50:VII.1313]

A. ...

1. If the department determines that a nursing facility provider has delinquent MDS resident assessments, for purposes of determining both average CMIs, such assessments shall be assigned the case-mix index associated with the PDPM group "BC1-delinquent" for all PDPM components. A delinquent MDS shall be assigned a CMI value equal to the lowest CMI in each PDPM component classification system.

B. - B.5.b. ...

c. If the percentage of unsupported MDS assessments in the total sample is greater than the threshold percentage as shown in column (B) of the table in Subparagraph e of this Paragraph, the impacted PDPM component(s) classification shall be recalculated for the unsupported MDS assessments based upon the available documentation obtained during the CMDR process. The nursing facility provider's CMI and resulting Medicaid rate shall be recalculated for the quarter in which the FCIR was used to determine the Medicaid rate. A follow-up CMDR

process described in Subparagraphs d and e of this Paragraph may be utilized at the discretion of the department.

d. ...

e. After the follow-up CMDR, if the percentage of unsupported MDS assessments in the total sample is greater than the threshold percentage as shown in column (B) of the following table, impacted PDPM component(s) classification shall be recalculated for the unsupported MDS assessments based upon the available documentation obtained during the CMDR process. The nursing facility provider's CMI and resulting Medicaid rate shall be recalculated for the quarter in which the FCIR 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 a documentation improvement plan with the department. Additional follow-up CMDR may be conducted at the discretion of the department.

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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 28:2537 (December 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:826 (March 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:528 (March 2017), LR 45:274 (February 2019), LR 51:

§20029. Supplemental Payments

A. - A.3.a.iv ...

b. Calculating Medicaid Rates Using Medicare Payment Principles. The prospective payment system (PPS), Medicare rates will be calculated based on Medicaid acuity data. The following is a summary of the steps involved.

i. The applicable PDPM classification for Medicaid residents is identified using each resident's minimum data set assessment. A full listing of Medicaid residents with the applicable Medicare PDPM classification is then generated.

(a). ...

ii. Rural and urban rate differentials, wage index adjustments, and value-based purchasing adjustments will be used to adjust the Medicare rate tables for each component of PDPM after the Medicaid listing is developed. The non-therapy ancillary component of PDPM will be adjusted to exclude the estimated portion of payments related to pharmacy, laboratory, and radiology services based on a statewide percentage derived from Medicare cost report data to account for differences between what the Medicare PPS rate covers and what the Medicaid program reimburses. Medicare rate tables will be applicable to SFY periods.

(a). ...

(b). Medicare rates for each Medicaid resident in the listing are calculated using the relevant Medicare rate tables for each period of the SFY and then averaged by nursing facility. The nursing facility's average rates are then pro-rated based on the length of active time of each Medicare rate table during the SFY. The calculated rate will be multiplied by an estimate of Medicaid paid claims days for the specified period. Medicaid paid claims days will be compiled from the state's Medicaid Management Information System's (MMIS) most recent 12 months, as of the development of the Medicaid supplemental payment calculation demonstration.

c. Determining Medicaid Payments for Medicaid Nursing Facility Residents. The most current Medicaid nursing facility reimbursement rates as of the development of the Medicaid supplemental payment calculation demonstration will be utilized. These reimbursement rates will be multiplied by Medicaid paid claims compiled from the state's MMIS system from the most recent 12 months, as of the development of the Medicaid supplemental payment calculation demonstration, to establish total Medicaid per diem payments. Total calculated Medicaid payments made outside of the standard nursing facility per diem are summed with total Medicaid reimbursement from the per diem payments to establish total Medicaid payments. Payments made outside of the standard nursing facility per diem are reimbursement for the following services.

i. - iii. ...

d. Repealed.

e. Calculating the Differential between the Calculated Medicare Payments for Medicaid Nursing Facility Residents, and Medicaid Payments for those Same Residents. The total annual Medicaid supplemental payment will be equal to the individual NSGO nursing facility's differential between their calculated Medicare payments and the calculated Medicaid payments for the applicable SFY, as detailed in the sections above.

4. - 5. ...

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 42:63 (January 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 43:529 (March 2017), LR 47:476 (April 2021), LR 51:

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.

Kimberly Sullivan, JD, Bureau of Health Services Financing, 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.

Bruce D. Greenstein
Secretary

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