DECLARATION OF EMERGENCY

Department of Health and Hospitals
Bureau of Health Services Financing

Nursing Facilities
Reimbursement Methodology
Minimum Data Set Assessments
(LAC 50:VII.1301, 1307, 1313 and 1315)

The Department of Health and Hospitals, Bureau of Health Services Financing amends LAC 50:VII.1301, §1307, §1313 and §1315 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.

In compliance with Act 694 of the 2001 Regular Session of the Louisiana Legislature, the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing repealed the provisions governing the prospective reimbursement methodology for private nursing facilities and established a new reimbursement methodology based on a case-mix price-based reimbursement system for private and public nursing facilities (*Louisiana Register*, Volume 28, Number 6). The department amended the June 20, 2002 Rule to incorporate new definitions and revised current definitions governing nursing facility reimbursements. The December 20, 2002 Rule also revised the provisions governing the submission of cost reports and adopted provisions governing verification of minimum data set (MDS) assessments and the appeal process for dispute of MDS review findings (*Louisiana Register,* Volume 28, Number 12).

The department promulgated an Emergency Rule which amended the provisions governing the reimbursement methodology for nursing facilities to revise the provisions governing MDS assessments in order to comply with new federal requirements (*Louisiana Register,* Volume 36, Number 10). The October 20, 2010 Emergency Rule also changed the date that MDS assessments are due. This Emergency Rule is being promulgated to continue the provisions of the October 20, 2010 Emergency Rule. This action is being taken to avoid sanctions from the Centers for Medicare and Medicaid Services for noncompliance with the federal mandate to utilize the new MDS assessment data.

Effective February 18, 2012, the Department of Health and Hospitals, Bureau of Health Services Financing amends the provisions governing the reimbursement methodology for nursing facilities to revise the provisions governing MDS assessments.

Title 50
PUBLIC HEALTH-MEDICAL ASSISTANCE
Part VII. Long Term Care Services
Subpart 1. Nursing Facilities
Chapter 13. Reimbursement
§1301. Definitions

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Assessment Reference Date-the date on the Minimum Data Set (MDS) used to determine the due date and delinquency of assessments. This date is used in the case-mix reimbursement system to determine the last assessment for each resident present in the facility and is included in the quarterly case-mix report.

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

Case-Mix MDS Documentation Review (CMDR)-a review of original legal medical record documentation on a randomly selected MDS assessment sample. The original legal medical record documentation supplied by the nursing facility is to support certain reported values that resulted in a specific RUG classification. The review of the documentation provided by the nursing facility will result in the RUG classification being supported or unsupported.

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Delinquent MDS Resident Assessment-an MDS assessment that is more than 121 days old, as measured by the Assessment Reference Date (ARD) field on the MDS.

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Facility Cost Report Period Case-Mix Index-the average of quarterly facility-wide average case-mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the facility's cost reporting period that is used to determine the medians. This average includes any revisions made due to an on-site CMDR.

Example: A January 1, 2011-December 31, 2011 cost report period would use the facility-wide average case-mix indices calculated for March 31, 2011, June 30, 2011, September 30, 2011 and December 31, 2011.

1. Repealed.

Facility-Wide Average Case-Mix Index-the simple average, carried to four decimal places, of all resident case-mix indices based on the last day of each calendar quarter. If a facility does not have any residents as of the last day of a calendar quarter or the average resident case-mix indices appear invalid due to temporary closure or other circumstances, as determined by the department, a statewide average case-mix index using occupied and valid statewide facility case-mix indices may be used.

Final Case-Mix Index Report (FCIR)-the final report that reflects the acuity of the residents in the nursing facility on the last day of the calendar quarter, referred to as the point-in-time.

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Minimum Data Set (MDS)-a core set of screening and assessment data, including common definitions and coding categories, that form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in the Medicaid Program. The items in the MDS standardize communication about resident problems, strengths, and conditions within facilities, between facilities, and between facilities and outside agencies. The Louisiana system will employ the current MDS assessment required and approved by the Centers for Medicare and Medicaid Services (CMS).

MDS Supportive Documentation Guidelines-the department's publication of the minimum medical record documentation guidelines for the MDS items associated with the RUG-III or its successor classification system. These guidelines shall be maintained by the department and updated and published as necessary.

On-Site MDS Review—Repealed.

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Point-in-Time-Repealed.

Preliminary Case Mix Index Report (PCIR)-the preliminary report that reflects the acuity of the residents in the nursing facility on the last day of the calendar quarter.

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RUG-III Resident Classification System—the resource utilization group used to classify residents. When a resident classifies into more than one RUG-III, or its successor's group, the RUG-III or its successor's group with the greatest CMI will be utilized to calculate the facility average CMI and Medicaid average CMI.

Summary Review Results Letter-a letter sent to the nursing facility that reports the final results of the case-mix MDS documentation review and concludes the review.

1. The Summary Review Results letter will be sent to the nursing facility within 10 business days after the final exit conference date.

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Unsupported MDS Resident Assessment-an assessment where one or more data items that are used to classify a resident pursuant to the RUG-III, 34-group, or its successor's resident classification system is not supported according to the MDS supporting documentation guidelines and a different RUG-III, or its successor, classification would result; therefore, the MDS assessment would 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 28:1790 (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 38:0000 (January 2012).

§1307. Case-Mix Index Calculation

A. The Resource Utilization Groups-III (RUG-III) Version 5.20, 34-group, or its successor, 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, or its successor, will be excluded from the average case-mix index calculation.

B. Effective with the January 1, 2011 rate setting, each resident in the facility, with a completed and submitted assessment, shall be assigned a RUG-III, 34-group, or its successor, on the last day of each calendar quarter. 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 shall be determined four times per year based on the last day of each calendar quarter.

C. Effective with the January 1, 2011 rate setting, 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 payor source on the last 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 28:1792 (August 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:0000 (January 2012).

§1313. Case-Mix Minimum Data Set Documentation Reviews and Case-Mix Index Reports

A. The department or its contractor shall provide each nursing facility with the Preliminary Case-Mix Index Report (PCIR) by approximately the fifteenth day of the second month following the beginning of a calendar quarter. The PCIR 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 Case-Mix Index Report (FCIR) (point-in-time) 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" or its successor. A delinquent MDS shall be assigned a CMI value equal to the lowest CMI in the RUG-III, or its successor, 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 Case-Mix MDS Documentation Reviews (CMDR) not less than two business days prior to the start of the 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 possible documentation that will be required to be available at the start of the on-site CMDR.

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 FCIR. The CMDR 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 CMDR, 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 CMDR.

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 CMDR.

4. After the close of the CMDR, the department or its contractor will submit its findings in a Summary Review Results (SRR) letter 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 CMDR.

a. If the percentage of unsupported assessments in the initial on-site CMDR sample is greater than 25 percent, the sample shall be expanded, and shall include the greater of 20 percent of the remaining resident assessments or 10 assessments.

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

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 below, the RUG-III, or its successor, classification shall be recalculated for the unsupported MDS assessments based upon the available documentation obtained during the CMDR process. The facility'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 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 CMDR will be given 90 days to correct their assessing and documentation processes. A follow-up CMDR may be performed at the discretion of the department at least 30 days after the facility's 90-day correction period. The department or its contractor shall notify the facility not less than two business days prior to the start of the CMDR 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 CMDR.

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, the RUG-III, or its successor, classification shall be recalculated for the unsupported MDS assessments based upon the available documentation obtained during the CMDR process. The facility'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 an MDS Documentation Improvement Plan with the Department of Health and Hospitals. Additional follow-up CMDR 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 and beyond	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), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:0000 (January 2012).

§1315. Appeal Process

A. If the facility disagrees with the CMDR 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 CMDR findings in the SRR letter. Otherwise, the results of the CMDR findings 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 of receipt of the request 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. …

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), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:0000 (January 2012).

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 Don Gregory, 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.

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Secretary

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