DECLARATION OF EMERGENCY

Department of Health
Bureau of Health Services Financing

Nursing Facilities—Optional State Assessment
(LAC 50:II.10123 and 20001)

The Department of Health, Bureau of Health Services Financing amends LAC 50:II.10123 and §20001 in the Medical Assistance Program as authorized by R.S. 36:254 and R.S. 46:2742 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.

Due to the Coronavirus Disease 2019 (COVID-19) public health emergency, the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) delayed the requirement for states to transition from the current resource utilization group (RUG-III/RUG-IV) case-mix classification model used under the Medicare skilled nursing facility prospective payment system to the patient driven payment model until October 1, 2019. In compliance with CMS requirements, the Department of Health, Bureau of Health Services Financing amends the provisions governing the standards for payment and reimbursement for nursing facilities in order to implement the patient driven payment model for case-mix classification and mandate use of the optional state assessment item set.

This action is being taken to avoid federal sanctions or penalties. It is anticipated that implementation of this Emergency Rule will have no fiscal impact to the Medicaid program for state fiscal year 2023-2024.

Effective October 1, 2023, the Department of Health, Bureau of Health Services Financing amends the provisions governing the standards for payment and reimbursement for nursing facilities in order to implement the patient driven payment model for case-mix classification and mandate use of the optional state assessment item set.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part II. Nursing Facilities
Subpart 3. Standards for Payment
Chapter 101. Standards for Payment for Nursing Facilities
Subchapter D. Resident Care Services
§10123. Comprehensive Assessment

A. - G.4.c. ...

H. Effective for assessments with assessment reference dates of October 1, 2023 and after, the department mandates the use of the optional state assessment (OSA) item set. The OSA item set is required to be completed in conjunction with each assessment and at each assessment interval detailed within this Section. The OSA item set must have an assessment reference date that is identical to that of the assessment it was performed in conjunction with.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153 and R.S. 46:2742.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996), amended by the Department of Health, Bureau of Health Services Financing, LR 46:695 (May 2020), LR 46:1684 (December 2020), LR 50:

Subpart 5. Reimbursement
Chapter 200. Reimbursement Methodology
§20001. General Provisions

A. Definitions

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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 nursing facility providers certified to participate in the Medicaid Program. The items in the MDS standardize communication about resident problems, strengths, and conditions within nursing facility providers, between nursing facility providers, and between nursing facility providers and outside agencies. The Louisiana system will employ the current required MDS assessment as approved by the Centers for Medicare and Medicaid Services (CMS), or as mandated by the Department of Health through the use of the optional state assessment (OSA).

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

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Patient Driven Payment Model (PDPM)—the proposed new 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.

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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:

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.

Stephen R. Russo, JD
Secretary

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