RATE DETERMINATION

The State Plan amendment and/or published rule are the final authority for rate setting for intermediate care facilities for the individuals with intellectual disabilities (ICF/IID). The authority for this rate setting system is found in LA R.S. 15: 1081-1086 and in Federal Regulations at 42 CFR 447.250 through 42 CFR 447.274.

Rate Structure

Private ICF/IID facilities are reimbursed on the Inventory for Client and Agency Planning (ICAP) rate methodology. This methodology is based on the facility's bed size and the individual's level of care. The ICAP scoring sheet is part of the admission papers reviewed by the Office for Citizens with Developmental Disabilities (OCDD).

The ICAP is a standardized instrument for assessing adaptive and maladaptive behavior and includes a service score which indicates the overall level of care, supervision or training the individual requires. The ICAP utilizes the following five support levels to describe the levels of support needed for individuals with disabilities:

1. Intermittent – supports on an "as needed basis." Characterized as episodic in nature, the person does not always need the support(s), or short-term supports needed during life-span transition (e.g., job loss or an acute medical crisis). Intermittent supports may be high or low intensity when provided;

2. Limited – supports characterized by consistency over time, time-limited but not of an intermittent nature, may require fewer staff members and less costs than more intense levels of support (e.g., time-limited employment training or transitional supports during the school to adult provided period);

3. Extensive – supports characterized by regular involvement (e.g., daily) in at least some environment (such as work or home) and not time-limited (e.g., long-term support and long-term home living support);

4. Pervasive – supports characterized by their constancy, high intensity; provided across environments; and/or potential life-sustaining nature. Pervasive supports typically involve more staff members and intrusiveness than do extensive or time-limited supports; and

5. Pervasive Plus – is a time-limited specific assignment to supplement required Level of Need services or staff for the provision of complex medical care (> 180 minutes

of nursing care a week) or to supplement required direct care staff (> 16 hours a week of 1:1 staff) due to extremely life threatening behavior. Requests for Pervasive Plus will be reviewed and approved by the Louisiana Department of Health (LDH) Pervasive Plus Committee.

Facilities are divided into peer groups, based on bed size. Peer groups are as follows:

1. 1 – 8 beds;
2. 9 – 15 beds;
3. 16 – 32 beds; and
4. 33 or more beds.

Resident Per Diem Rates

Resident per diem rates are calculated based on information reported on the cost report. ICF/IID will receive a rate for each resident. The rates are based on cost components appropriate for an economic and efficient ICF/IID providing quality service. The resident per diem rates represent the best judgment of the state to provide reasonable and adequate reimbursement required to cover the costs of economic and efficient ICF/IID.

Cost data used in setting base rates is from the latest available audited or desk reviewed cost reports. The initial rates are adjusted to maintain budget neutrality upon transition to the ICAP reimbursement methodology. For rate periods between rebasing, the rates are trended forward using the index factor contingent upon appropriation by the legislature.

A beneficiary's per diem rate is the sum of the following:

1. Direct care per diem rate;
2. Care related per diem rate;
3. Administrative and operating per diem rate;
4. Capital rate; and
5. Provider fee.

Determination of Rate Components

Direct Care Per Diem Rate

The direct care per diem rate is a set percentage over the median adjusted for the acuity of the resident based on the ICAP, tier based on peer group. The direct care per diem rate is determined as follows:

1. Median Cost: The direct care per diem median cost for each ICF/IID is determined by dividing the facility's total direct care costs reported on the cost report by the facility's total days during the cost reporting period. Direct care costs for providers in each peer group are arrayed from low to high and the median (50^{th} percentile) cost is determined for each peer group;

2. Median Adjustment: The direct care component shall be adjusted to 105 percent of the direct care per diem median cost in order to achieve reasonable access to care;

3. Inflationary Factor: These costs are trended forward from the midpoint of the cost report period to the midpoint of the rate year using the index factor;

4. Acuity Factor: Each of the ICAP levels will have a corresponding acuity factor. The median cost by peer group, after adjustments, shall be further adjusted by the acuity factor (or multiplier) as follows:

ICAP Support Level	Acuity Factor (Multiplier)
Pervasive	1.35
Extensive	1.17
Limited	1.00
Intermittent	.90

5. Direct Service Provider Wage Enhancement: For dates of service on or after February 2007. The direct care reimbursement to ICD/IID providers must include a direct care service worker incentive in the amount of $2 per hour. It is the intent that this wage enhancement be paid to the direct care staff. Non-compliance with the wage enhancement shall be subject to recoupment:

    a. At least 75 percent of the wage enhancement must be paid to the direct support professional and 25 percent must be used to pay employer-related taxes, insurance and employee benefits; and

b. The wage enhancement will be added on to the current ICAP rate methodology as follows:

i. Per diem rates for beneficiaries residing in 1-8 bed facilities will increase $16.00;

ii. Per diem rates for beneficiaries residing in 9-16 bed facilities will increase $14.93; and

iii. Per diem rates for beneficiaries residing in 16+ bed facilities will increase $8.

The direct care costs consist of all the costs related to direct care interaction with the beneficiary. Direct care costs include the following:

1. In-house and contractual salaries;
2. Benefits;
3. Payroll taxes for all positions directly related to patient care;
4. Worker's compensation;
5. Medical services (routine, and extraordinary);
6. Medical supplies;
7. Therapeutic and training supplies;
8. Habilitation costs;
9. Recreational supplies; and
10. Consultants.

Care Related Per Diem Rate

The care related per diem rate shall be a statewide price at a set percentage over the median and shall be determined as follows:

1. Median cost – the care related per diem median cost for each ICF/IID is determined by dividing the facility's total care related costs reported on the cost report by the facility's actual total resident days during the cost reporting period. Care related costs for all providers are arrayed from low to high and the median (50^{th} percentile) cost is determined;

2. Median Adjustment – the care related component shall be adjusted to 105 percent of the care related per diem median cost in order to achieve reasonable access to care; and

3. Inflationary Factor – these costs shall be trended forward from the midpoint of the cost report period to the midpoint of the rate year using the index factor.

Care related costs include the following:

1. In-house and contractual salaries;

2. Benefits;

3. Payroll taxes;

4. Supplies that help support direct care but do not directly involve caring for the patient and ensuring their well-being (e.g., dietary and educational); and

5. Personal items, such as clothing and personal hygiene items.

Administrative and Operating Per Diem Rate

The administrative and operating per diem rate shall be a statewide price at a set percentage over the median, tier based on peer group. The administrative and operating component shall be determined as follows:

1. Median cost – the administrative and operating per diem median cost for each ICF-IID is determined by dividing the facility's total administrative and operating costs reported on the cost report by the facility's actual total resident days during the cost reporting period. Administrative and operating costs for all providers are arrayed from low to high and the median (50^{th} percentile) cost is determined;

2. Median Adjustment – the administrative and operating component shall be adjusted to 103 percent of the administrative and operating per diem median cost in order to achieve reasonable access to care; and

3. Inflationary Factor – these costs shall be trended forward from the midpoint of the cost report period to the midpoint of the rate year using the index factor.

Administrative and operating costs include the following:

1. In-house and contractual salaries;
2. Benefits;
3. Payroll taxes for administration and plant operation maintenance staff;
4. Utilities;
5. Accounting;
6. Insurance;
7. Maintenance staff;
8. Maintenance supplies;
9. Laundry and linen;
10. Housekeeping; and
11. Other administrative type expenditures.

Capital Per Diem Rate

The capital per diem rate shall be a statewide price at a set percentage over the median, tier based on peer group. The capital per diem rate shall be determined as follows:

1. Median costs – the capital per diem median cost for each ICF/IID is determined by dividing the facility's total capital costs reported on the cost report by the facility's actual total resident days during the cost reporting period. Capital costs for providers of each peer group are arrayed from low to high and the median (50^{th} percentile) cost is determined for each peer group;
2. Median adjustment – the capital cost component shall be adjusted to 103 percent of the capital per diem median cost in order to achieve reasonable access to care; and

3. Inflationary factor – capital costs shall not be trended forward.

Capital costs include the following:

1. Depreciation;
2. Interest expense on capital assets;
3. Leasing expenses;
4. Property taxes; and
5. Other expenses related to capital assets.

Provider Fee

The provider fee shall be calculated by the department in accordance with state and federal rules. Effective April 1, 2014, the provider fee is $16.15.

A bed fee shall be paid by each ICF/IID facility for each bed utilized for the provision of care on a daily basis. ICF/IID facilities shall provide documentation quarterly of utilization for all licensed beds in conjunction with payment of the fee. Quarters are defined as:

1. December through February;
2. March through May;
3. June through August; and
4. September through November.

LDH will mail a Quarterly Fee Report to each ICF/IID before the end of the quarter. Reports of quarterly utilization and fees shall be submitted to the department and shall be due on the 20th calendar day of the month following the close of the quarter and shall be deemed delinquent on the 30th calendar day of the month. Submission of the report is mandatory regardless if no fee is due.

The rates for the 1-8 bed peer group shall be set based on costs in accordance with the direct care per diem rate, care-related per diem rate, Administrative and operating per diem rate, capital per diem rate and provider fee. The reimbursement rates for peer groups of larger facilities will also be set in accordance with the same criteria; however, the rates will be limited as follows:

1. The 9-15 peer group reimbursement rates will be limited to 95 percent of the 1-8 bed peer group reimbursement rates;

2. The 16-32 bed peer group reimbursement rates will be limited to 95 percent of the 9-15 bed peer group reimbursement rates; and

3. The 33 and greater bed peer group reimbursement rates will be limited to 95 percent of the 16-32 bed peer group reimbursement rates.

Adjustments to the Medicaid daily rate may be made when changes occur that eventually will be recognized in updated cost report data (such as a change in the minimum wage or Federal Insurance Contributions Act (FICA) tax rates). These adjustments would be effective until such time as the data base used to calculate rates 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 LDH Secretary makes the final determination as to the amount and when adjustments to rates are warranted.

A facility requesting a pervasive plus rate supplement shall bear the burden of proof in establishing the facts and circumstances necessary to support the supplement in a format and with supporting documentation specified by the LDH ICAP Review Committee. The LDH ICAP Review Committee shall make a determination of the most appropriate staff required to provide requested supplemental services. The amount of the Pervasive Plus supplement shall be calculated using the Louisiana Civil Service pay grid for the appropriate position as determined by the LDH ICAP Review Committee and shall be the 25th percentile salary level plus 20 percent for related benefits times the number of hours approved.

Other Beneficiary Specific Adjustments to the Rate

A facility may request a beneficiary specific rate supplement for reimbursement of the costs for enteral nutrition, ostomy or tracheotomy medical supplies or a vagus nerve stimulator. The provider must submit sufficient medical supportive documentation to the LDH ICAP Review Committee to establish medical need for enteral nutrition, ostomy or tracheotomy medical supplies. The amount of reimbursement determined by the ICAP Review Committee shall be based on the average daily cost for the provision of the medical supplies. The provider must submit annual documentation to support the need for the adjustment to the rate.

Prior authorization for implementation for the vagus nerve stimulator shall be requested after the evaluation has been completed but prior to stimulator implantation. The request to initiate implantation shall come from the multi-disciplinary team as a packet with the team's written decision regarding the beneficiary's candidacy for the implant and the results of all pre-operative

testing. The prior authorization form for the device and surgeon shall be included in the packet forwarded to the prior authorization unit.

The amount of reimbursement shall be the established fee on the Medicaid Fee Schedule for medical equipment and supplies.

ICAP Requirements

An Inventory for Client and Agency Planning (ICAP) assessment must be completed for each beneficiary of ICF/IID services upon admission and while residing in an ICF/IID in accordance with departmental regulations. Providers must keep a copy of the beneficiary's current ICAP protocol and computer scored summary sheets in the beneficiary's file. If a beneficiary has changed ICAP service level, providers must also keep a copy of the beneficiary's ICAP protocol and computer scored summary sheets supporting the prior level. ICAPs must reflect the resident's current level of care.

ICAP Monitoring

ICAP scores and assessments will be subject to review by LDH and its contracted agents. The reviews of ICAP submissions include, but are not limited to the following:

1. Reviews when statistically significant changes occur within an ICAP submission or submissions;

2. Random selections of ICAP submissions;

3. Desk reviews of a sample of ICAP submissions; and

4. On-site field reviews of ICAPs.

ICAP Review Committee

The ICAP Review Committee reviews requests for the pervasive plus supplement or medical supply add-on. Pervasive plus is a time-limited specific assignment of staff to supplement the required level of need services which may include staff to provide life sustaining complex medical care (> 180 minutes of nursing care a week) or to supplement required direct care staff (>16 hours a week of 1:1 staff) due to dangerous life threatening behavior so serious that the beneficiary could cause serious physical injury to self or others and requires additional trained support staff to be at "arm's length" during waking hours. Medical add-on covers the average daily cost for certain medical supplies.

Providers requesting the pervasive plus supplement or medical add-on rate supplement bear the burden of proof in establishing the facts and circumstances necessary to support the request with supporting documentation specified by the ICAP Review Committee.

For providers receiving pervasive plus supplements or other client specific adjustment to the rate, the facility-wide direct care floor is established at 94 percent of the per diem direct care payment and at 100 percent of any rate supplements or add on payments received by the provider, including the pervasive plus supplement, the complex care add-on payment and other client specific adjustment to the rate. The facility-wide direct care floor will be applied to the cost reporting year in which the facility receives a pervasive plus supplement and/or client specific rate adjustment. In no case however, shall a facility receiving a pervasive plus supplement and/or client specific rate adjustment have total facility payments reduced to less than 104 percent of the total facility cost as a result of imposition of the direct care floor.

The support staff member assigned to supervise the person has no other duties during the assignment. The assignment is specific to the type of and duration of services to be provided. The assigned staff is educated and able to follow the behavior management plan. **The support member does not replace the minimum staff required for the level of care (LOC).**

The ICAP Review Committee shall represent LDH should a provider request an informal reconsideration regarding the Regional Health Standards' determination. The ICAP Review Committee shall make final determination on any ICAP level of care changes prior to the appeals process. The ICAP Review Committee shall be made up of the following:

1. Director of the Health Standards Section or their appointee;

2. Director of Rate and Audit Review Section or their appointee;

3. Assistant Secretary for OCDD or their appointee; and

4. Other persons as appointed by the secretary.

When an ICAP score is determined to be inaccurate, the department shall notify the provider and request documentation to support the level of care. If the additional information does not support the level of care, an ICAP rate adjustment will be made to the appropriate ICAP level effective the first day of the month following the determination.

Facility Direct Care Staffing Requirements

There must be a responsible direct care staff on duty and awake on a 24 hour basis (when beneficiaries are present) to take prompt, appropriate action in case of injury, illness, fire or other emergency.

There must be sufficient direct care staff to manage and supervise beneficiaries in accordance with their individual program plans. Direct care staff is defined as present on-duty staff calculated over all shifts in a 24-hour period for each defined residential unit. Minimum staffing ratios of direct care staff to beneficiary does not include any 1:1 staff provided for under Pervasive Plus assignments. Pervasive Plus assignments are in addition to minimum staffing requirements.

Complex Care

Effective for dates of service on or after October 1, 2014, non-state intermediated care facilities for individuals with intellectual disabilities (ICF/IID), may receive an add-on payment to the per diem rate for providing complex medical care to Medicaid beneficiaries who require such services. The add-on rate adjustment shall be a flat fee amount and may consist of payment for any of the following components:

1. Equipment only (only Medicaid allowable equipment);
2. Direct service worker (DSW);
3. Nursing only;
4. Equipment and DSW;
5. DSW and nursing;
6. Nursing and equipment; or
7. DSW, nursing and equipment.

Non-State owned ICFs/IID, may qualify for an add-on rate for beneficiaries meeting documented major medical or behavioral complex care criteria. This must be documented on the complex support need screening tool provided by the Department. All medical documentation indicated by the screening tool form and any additional documentation requested by the Department must be provided to qualify for the add-on payment. Documentation must be recent within the last year.

The complex support need screening tool shall be completed and submitted to the Department annually from the date of initial approval of each add-on payment. This annual submittal shall be accompanied by all medical documentation indicated by the screening tool form and any additional documentation requested by the Department. It is the provider's responsibility to submit for renewals annually.

In order to meet the complex care criteria, the presence of a significant medical or behavioral health need must exist and be documented. This must include:

1. Endorsement of at least one qualifying condition with supporting documentation; and

2. Endorsement of symptom severity in the appropriate category based on qualifying condition(s) with supporting documentation.

Qualifying conditions for complex care must include at least one of the following as documented on the complex support need screening tool:

1. Significant physical and nutritional needs requiring full assistance with nutrition, mobility and activities of daily living;

2. Complex medical needs/medically fragile; or

3. Complex behavioral/mental health needs.

Enhanced supports must be already being provided and verified with supporting documentation to qualify for the add-on payments. Additional criteria and information is found in the Louisiana Administrative Code (LAC) 50: VII, §32915.

Complex Care packets are received and reviewed by the complex care team. All packets are initially submitted to the complex care team coordinator. If the information is received in its entirety and reviewed by the complex care team prior to the 15th of the month, the rate will be approved retroactively to the 1st of the month in which it was submitted.

If the information is received in its entirety and reviewed after the 15th of the month, the rate will be effective the first day of the next month. This is done to reduce billing errors and to encourage complete information submissions. Only recent relative information is considered when determining the appropriate add-on rate.

Providers receiving complex care add-on rates will be required to meet the direct care floor at 85 percent of the direct care component of the rate and 100 percent of the add-on amount. This is applied facility wide and within the cost report year the complex care add-on is received.

If a facility is receiving both the complex care add-on and pervasive plus add-on in the same facility, then the direct care floor is facility-wide at 94 percent of the direct care component of the rate and 100 percent of the add-on amounts.

Determinations for pervasive plus or complex care add-on rates will be made in accordance with what is best for the beneficiary and what the beneficiary needs or would best benefit from. If it is determined the beneficiary would best be served with 1:1 supports under the pervasive plus supplement, the provider will be offered this option. If the provider refuses, then complex care is not an alternative as the two add-on rates serve different purposes.

Transfer of Beneficiaries with Add-On Rates

If a beneficiary is receiving an add-on payment for pervasive plus, complex care or other specific adjustment to the rate, and transfers to a new provider, the transferring provider must notify the ICAP coordinator of the transfer. The new provider has the responsibility of notifying the Department if they do not want to continue with the add-on payment. This notification must be in writing and submitted to the Complex Care team coordinator and/or ICAP coordinator within seven days of receiving the new transfer. Failure of the new provider to notify the Department will result in the facility being required to meet the facility-wide direct care floor without further notification from the Department.

Minimum Ratios of Direct Care Staff to Beneficiaries:

Description	Staff to Beneficiary Ratio
For each defined residential living unit serving: 1. Children under the 12 years of age; 2. Severely and profoundly retarded beneficiaries; 3. Beneficiaries with severe physical disabilities; 4. Beneficiaries who are aggressive, assaulting or security risks; or 5. Beneficiaries who manifest severely hyperactive or psychotic-like behavior.	**1 to 3.2**
For each defined residential living unit serving moderately regarded beneficiaries	**1 to 4**
For each defined residential living unit serving beneficiaries who function within the range of mild retardation	**1 to 6.4**