RATE DETERMINATION

The State Plan Amendment and/or published rule are the final authority for rate setting for Intermediate Care Facilities for the Developmentally Disabled. 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/DD 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.

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 by individuals with mental retardation and other developmental disabilities:

- 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.

- 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).

- 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).

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

- 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 DHH Pervasive Plus Committee.

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

- 1 – 8 beds,
- 9 – 15 beds,
- 16 – 32 beds,
- 33 or more beds.

Resident Per Diem Rates

Resident per diem rates are calculated based on information reported on the cost report. ICF/DDs will receive a rate for each resident. The rates are based on cost components appropriate for an economic and efficient ICF/DD 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/DDs.

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 resident's per diem rate is the sum of the following:

- Direct care per diem rate,
- Care related per diem rate,
- Administrative and operating per diem rate,
- Capital rate, and
- 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:

- Median Cost

  The direct care per diem median cost for each ICF/DD 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.

- 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.

- 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.

- 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

- Direct Service Provider Wage Enhancement

For dates of service on or after February 9, 2007, the direct care reimbursement in the amount of $2 per hour to ICF/DD providers must include a direct care service worker wage enhancement incentive. 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.

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.

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

- Per diem rates for recipients residing in 1-8 bed facilities will increase $16.00,
- Per diem rates for recipients residing in 9-16 bed facilities will increase $14.93, and
- Per diem rates for recipients residing in 16+ bed facilities will increase $8.

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

- In-house and contractual salaries,
- Benefits,
- Payroll taxes for all positions directly related to patient care,
- Worker's compensation,
- Medical services (routine, and extraordinary),
- Medical supplies,
- Therapeutic and training supplies,
- Habilitation costs,
- Recreational supplies, and
- 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:

- Median cost – the care related per diem median cost for each ICF/DD 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.

- 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.

- 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:

- In-house and contractual salaries,

- Benefits,

- Payroll taxes,

- 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

- 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:

- Median cost – the administrative and operating per diem median cost for each ICF-MR 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.

- 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.

- 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:

- In-house and contractual salaries,
- Benefits,
- Payroll taxes for administration and plant operation maintenance staff,
- Utilities,
- Accounting,
- Insurance,
- Maintenance staff,
- Maintenance supplies,
- Laundry and linen,
- Housekeeping, and
- 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:

- Median costs – the capital per diem median cost for each ICF/DD 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 (50th percentile) cost is determined for each peer group.

- 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.

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

Capital costs include the following:

- Depreciation,

- Interest expense on capital assets,

- Leasing expenses,

- Property taxes, and

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

- December through February,

- March through May,

- June through August, and

- September through November.

DHH will mail a Quarterly Fee Report to each ICF/DD 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:

- The 9-15 peer group reimbursement rates will be limited to 95 percent of the 1-8 bed peer group reimbursement rates.
- The 16-32 bed peer group reimbursement rates will be limited to 95 percent of the 9-15 bed peer group reimbursement rates.
- 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 FICA 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 secretary of the Department of Health and Hospitals 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 DHH ICAP Review Committee. The DHH 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 DHH ICAP Review Committee and shall be the 25th percentile salary level plus 20 percent for related benefits times the number of hours approved.

Other Recipient Specific Adjustments to the Rate

A facility may request a recipient 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 DHH 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 recipient'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 recipient of ICF/DD services upon admission and while residing in an ICF/DD in accordance with departmental regulations. Providers must keep a copy of the recipient's current ICAP protocol and computer scored summary sheets in the recipient's file. If a recipient has changed ICAP service level, providers must also keep a copy of the recipient'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 DHH and its contracted agents. The reviews of ICAP submissions include, but are not limited to the following:

- Reviews when statistically significant changes occur within an ICAP submission or submissions,
- Random selections of ICAP submissions,
- Desk reviews of a sample of ICAP submissions, and
- 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 or to supplement required direct care staff due to dangerous life threatening behavior so serious that the recipient could cause serious physical injury to self or others and requires additional trained support staff to be at "arms 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.

The ICAP Review Committee shall represent DHH 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:

- Director of the Health Standards Section or his/her appointee,
- Director of Rate and Audit Review Section or his/her appointee,
- Assistant Secretary for the Office for Citizens with Developmental Disabilities or his/her appointee, and
- 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 recipients 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 recipients 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 Ratios of Direct Care Staff to Recipients:

Description	Staff to Recipient Ratio
For each defined residential living unit serving • children under the age of 12, • severely and profoundly retarded recipients, • recipients with severe physical disabilities,	**1 to 3.2**

• recipients who are aggressive, assaulting or security risks, or • recipients who manifest severely hyperactive or psychotic-like behavior	
For each defined residential living unit serving moderately regarded recipients	**1 to 4**
For each defined residential living unit serving recipients who function within the range of mild retardation	**1 to 6.4**

Minimum Direct Care Staffing Patterns (Based on Federal Requirements):

Facilities with 8 beds or less

Intermittent		Limited		Extensive		Pervasive	
Day	1:5	Day	1:4	Day	1:3	Day	1:2
Eve	1:5	Eve	1:4	Day	1:3	Eve	1:2
Night	1:6	Night	1:6	Night	1:6	Night	1:6

Facilities with 9-13 beds

Intermittent		Limited		Extensive		Pervasive	
Day	1:5	Day	1:4	Day	1:3	Day	1:2.5
Eve	1:5	Eve	1:4	Day	1:3	Eve	1:2.5
Night	1:10	Night	1:10	Night	1:10	Night	1:7.5

Facilities with 14 beds or more

Intermittent		Limited		Extensive		Pervasive	
Day	1:7	Day	1:6	Day	1:5	Day	1:3
Eve	1:7	Eve	1:6	Day	1:5	Eve	1:3
Night	1:20	Night	1:20	Night	1:20	Night	1:20