§32903. Rate Determination

A. Resident per diem rates are calculated based on information reported on the cost report. ICFs/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.

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

C. A resident's per diem rate will be the sum of:

1. direct care per diem rate;

2. care related per diem rate;

3. administrative and operating per diem rate;

4. capital rate;

5. provider fee; and

6. dental pass-through/add-on per diem rate (effective for dates of service on or after May 1, 2023).

D. Determination of Rate Components

1. The direct care per diem rate shall be 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 shall be determined as follows.

a. 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 (50th percentile) cost is determined for each peer group.

b. 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.

c. 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.

d. 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

e. 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/IDD providers shall 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.

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

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

(a). Per diem rates for recipients residing in 1-8 bed facilities will increase $16.00;

(b). Per diem rates for recipients residing in 9-16 bed facilities will increase $14.93; and

(c). Per diem rates for recipients residing in 16+ bed facilities will increase $8.

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

a. 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 (50th percentile) cost is determined.

b. 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.

c. 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.

3. 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.

a. 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 (50th percentile) cost is determined.

b. 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.

c. 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.

4. 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.

a. Median Cost. 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 (50th percentile) cost is determined for each peer group.

b. 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.

c. Inflationary Factor. Capital costs shall not be trended forward.

d. The provider fee shall be calculated by the department in accordance with state and federal rules.

i. Effective for dates of service on or after April 1, 2014, the add-on amount to each ICF/ID's per diem rate for the provider fee shall be increased to $16.15 per day.

5. The dental add-on per diem rate shall be a statewide price, and the pass-through, once calculated, will be facility specific. This pass-through/add-on may be adjusted annually and will not follow the rebasing and inflationary adjustment schedule. The dental pass-through/add-on per diem rate shall be determined as follows:

a. Prior to inclusion of these costs on facility cost reports, a per diem add on will be created based on estimates provided by the state's actuary and should reflect the costs associated with those basic dental services that are excluded from the dental PMPMs paid to the Louisiana Medicaid dental managed care entity(ies).

b. The above dental add-on per-diem, but not the pass-through rate, paid to each facility will be subject to a wholly separate and distinct floor calculation for each cost

report year that the per-diem is in effect, beginning July 1, 2023. The total sum of the per-diem add-on paid to each facility will be compared to each facilities costs associated with basic dental services that are excluded from the dental PMPMs paid to the Louisiana Medicaid dental managed care entity(ies). Should 95 percent of the total per-diem add-on paid exceed the facilities noted cost, the facility shall remit to the bureau the difference between these two amounts.

c. Once these dental expenses have been recognized in a facility cost report with a year ended on or after June 30, 2024 that is utilized in a rate rebase period, the add-on will no longer be paid to that facility and a facility specific pass-through per-diem rate will be calculated as the total dental cost reported on the cost report divided by total cost report patient days. These per-diem rates and costs will follow the same oversight procedures as noted at Section 32909. The facility specific pass-through per-diem may be reviewed and adjusted annually, at the discretion of the department.

E. The rates for the 1-8 bed peer group shall be set based on costs in accordance with §32903.B–D.4.d. The reimbursement rates for peer groups of larger facilities will also be set in accordance with §32903.B–D.4.d; however, the rates, excluding any dental pass-through/add-on 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.

3. The 33 and greater bed peer group reimbursement rates will be set in accordance with §32903.B–D.4.d, limited to 95 percent of the 16-32 bed peer group reimbursement rates.

F. Rebasing of rates will occur at least every three years utilizing the most recent audited and/or desk reviewed cost reports.

G. 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.

H. 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.

1. The LDH ICAP Review Committee shall make a determination of the most appropriate staff required to provide requested supplemental services.

2. 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.

I. Other Client Specific Adjustments to the Rate. A facility may request a client specific rate supplement for reimbursement of the costs for enteral nutrition, ostomy or tracheotomy medical supplies or a vagus nerve stimulator.

1. 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.

a. 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.

b. The provider must submit annual documentation to support the need for the adjustment to the rate.

2. 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 PA-01 form for the device and surgeon shall be included in the packet forwarded to Unisys.

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

J. Effective for dates of service on or after September 1, 2009, the reimbursement rate for non-state intermediate care facilities for persons with developmental disabilities shall be increased by 1.59 percent of the per diem rate on file as of August 31, 2009.

K. Effective for dates of service on or after August 1, 2010, the per diem rates for non-state intermediate care facilities for persons with developmental disabilities (ICFs/IID) shall be reduced by 2 percent of the per diem rates on file as of July 31, 2010.

1. Effective for dates of service on or after December 20, 2010, non-state ICFs/IID which have downsized from over 100 beds to less than 35 beds prior to December 31, 2010 shall be excluded from the August 1, 2010 rate reduction.

L. Effective for dates of service on or after August 1, 2010, the per diem rates for ICFs/IID which have downsized from over 100 beds to less than 35 beds prior to December 31, 2010 shall be restored to the rates in effect on January 1, 2009.

M. Effective for dates of service on or after July 1, 2012, the per diem rates for non-state intermediate care facilities for persons with developmental disabilities (ICFs/IID) shall be reduced by 1.5 percent of the per diem rates on file as of June 30, 2012.

N. Pursuant to the provisions of Act 1 of the 2020 First Extraordinary Session of the Louisiana Legislature, effective for dates of service on or after July 1, 2020, private ICF/IID facilities that downsized from over 100 beds to less than 35 beds prior to December 31, 2010 without the benefit of a cooperative endeavor agreement (CEA) or transitional rate and who incurred excessive capital costs, shall have their per diem rates (excluding provider fees) increased by a percent equal to the percent difference of per diem rates (excluding provider fees and dental pass through) they were paid as of June 30, 2019. See chart below with the applicable percentages:

	Intermittent	Limited	Extensive	Pervasive
1-8 beds	6.2 percent	6.2 percent	6.2 percent	6.1 percent
9-15 beds	3.2 percent	6.2 percent	6.2 percent	6.1 percent
16-32 beds	N/A	N/A	N/A	N/A
33+ beds	N/A	N/A	N/A	N/A

1. The applicable differential shall be applied anytime there is a change to the per diem rates (for example, during rebase, rate reductions, inflationary changes, or special legislative appropriations). This differential shall not extend beyond December 31, 2024.

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 31:2253 (September 2005), amended LR 33:462 (March 2007), LR 33:2202 (October 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:1555 (July 2010), LR 37:3028 (October 2011), LR 39:1780 (July 2013), LR 39:2766 (October 2013), LR 41:539 (March 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 47:370 (March 2021), LR 49:687 (April 2023).