2. Rate Determination

a. For dates of service on or after January 1, 2003, the Medicaid daily rates shall be based on a case-mix price based reimbursement system. Rates shall be calculated from cost report and other statistical data. Effective January 1, 2003, the cost data used in rate setting will be from cost reporting periods ending July 1, 2000 through June 30, 2001. Effective July 1, 2004, and every second year thereafter, the base resident-day-weighted median costs and prices shall be rebased using the most recent four month or greater unqualified audited or desk reviewed cost reports that are available as of the April 1 prior to the July 1 rate setting or the Department may apply a historic audit adjustment factor to the most recently filed cost reports. For rate periods between rebasing, an index factor shall be applied to the base resident-day weighted medians and prices.

Effective with the January 1, 2017 rate setting, resident acuity will be measured utilizing the time-weighted acuity measurement system.

For the cost reporting periods utilized in the next rebase of rates on or after July 1, 2017, the calendar quarter case mix index averages will be calculated using the time-weighted acuity measurement system, and be inclusive of MDS assessments available as of the date of the applicable quarterly FCIRs. This average includes any revisions made due to an on-site CMDR.

EXAMPLE:
A January 1, 2015-December 31, 2015 cost report period would use the time-weighted facility-wide average case mix indices calculated for the four quarters ending March 31, 2015, June 30, 2015, September 30, 2015 and December 31, 2015.

Effective with the January 1, 2017 rate setting, resident case mix indices will be calculated utilizing the time-weighted acuity measurement. If a nursing facility provider does not have any residents during the course 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 nursing facility provider case mix indices may be used.

Adjustments to the Medicaid daily rate may be made when changes occur that will eventually be recognized in updated cost report data. These rates will be effective until such time that the database used to calculate rates, fully reflects the change.

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Reimbursement rates for the 33 or more beds peer group will be limited to 95 percent of the 16-32 bed peer group reimbursement rates.

Per Diem Rate Adjustments

Effective for dates of service on or after February 20, 2009, the reimbursement rate shall be reduced by 3.5 percent of the per diem rate on file as of February 19, 2009.

Effective for dates of service on or after September 1, 2009, the reimbursement rate shall be increased by 1.59 percent of the per diem rate on file as of August 31, 2009.

Effective for the dates of service on or after August 1, 2010, the reimbursement rate shall be reduced by 2 percent of the per diem rates on file as of July 31, 2010.

Effective for the dates of service on or after August 1, 2010, 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.

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.

Effective for dates of service on or after July 1, 2020, private ICFs/IID 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) with LDH 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) they were paid as of June 30, 2019, as follows:

Peer Groups	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

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.

Adjustments to the Medicaid daily rate may be made when changes occur that will eventually be recognized in updated cost report data. These rates will be effective until such time that the database used to calculate rates, fully reflects the change.

4. Rebasing

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

5. Requests for Supplemental Services

a. Requests for pervasive plus rate supplement must be reviewed and approved by the LDH ICAP Review Committee. 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 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 ICAP Review Committee and shall be the 25th percentile salary level plus 20 percent for related benefits times the number of hours approved.

b. 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, tracheotomy medical supplies or a vagus nerve stimulator. The provider must submit sufficient medical supportive documentation to the 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.

Sufficient medical supportive documentation must be submitted to the Prior Authorization Unit to establish medical necessity. The amount of reimbursement shall be the established fee on the Medicaid Fee Schedule for medical equipment and supplies.

6. ICAP Requirements

An ICAP must be completed for each recipient 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 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.

Providers must submit a new ICAP to Regional Health Standards office when the resident's condition reflects a change in the ICAP level that indicates a change in reimbursement.

7. 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 reviews when statistically significant changes occur with ICAP submission(s).