

STATE OF LOUISIANA

III. METHOD FOR REIMBURSEMENT TO INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

A. INTRODUCTION

Intermediate Care Facilities for the Mentally Retarded (ICF/MR) are defined as intermediate care facilities whose primary purpose is to provide health or rehabilitative services for mentally retarded individuals or persons with related conditions and which meet the standards in Subpart D or Part 483 of the Code of Federal Regulations.

B. PROVIDER GROUPING

Providers are divided into two major groups, Public and Private.

1. Public ICF/MR Facilities

- a. State-owned or operated facilities.
- b. A quasi-public facility is an ICF/MR facility that:
 - i. is an organization that is a component unit of a governmental reporting entity, and
 - ii. receives funding in excess of \$25,000 directly from the owner governing body for operation of the facility.

2. Private ICF/MR Facilities

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Included under this classification are private proprietary and nonprofit facilities who are grouped based upon peer group.

Peer group classifications are as follows:

- a. 1-8 beds;
- b. 9-15 beds;
- c. 16-32 beds;
- d. 33 or more beds.

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C. REIMBURSEMENT TO PUBLIC ICF/MR PROVIDERS

- 1. Effective February 9, 2003, Medicaid payments to state-owned and operated ICFs/MR shall be based on the basic Medicare formula for determining the routine service cost limits, as follows:
 - a. Calculate each state owned and operated ICF/MR's per diem routine costs in a base year;
 - b. Inflate each facility's routine cost per diem to the rate year using the skilled nursing facility (SNF) market basket index of inflation;
 - c. Inflate each facility's routine cost per diem determined in b. by 12%;

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d. Each state-owned and operated facility's capital and ancillary costs will be paid on a "pass-through" basis.

The sum of the calculations for routine service costs and the capital and ancillary costs "pass-through" shall be the per diem rate for each state-owned and operated ICF/MR. The base year cost reports to be used for the initial calculations shall be the cost reports for the fiscal year ended June 30, 2002.

Effective for the dates on or after October 1, 2012, a transitional Medicaid reimbursement rate of \$302.08 per day per individual shall be established for a public ICF/DD facility over 50 beds that is transitioning to a private provider, as long as the provider meets the following criteria:

- a. shall have a fully executed agreement with the Office for Citizens with Developmental Disabilities for the private operation of the facility;
- b. shall have a high concentration of medically fragile individuals being served, as determined by DHH. For the purposes of these provisions, a medically fragile individual shall refer to an individual who has a medically complex condition characterized by multiple, significant medical problems that require extended care;
- c. incurs or will incur higher existing costs not currently captured in the private ICF/DD rate methodology; and
- d. shall agree to downsizing and implement a pre-approved OCDD plan.

Any ICF/DD home to which individuals transition to satisfy downsizing requirements, shall not exceed 6-8 beds.

Effective for the dates on or after October 1, 2013, the transitional Medicaid reimbursement rate shall only be for the period of transition, which is defined as the term of the agreement or a period of four years, whichever is shorter. The transitional Medicaid reimbursement rate is all inclusive and incorporates the following cost components:

- a. direct care staffing;
- b. medical/nursing staff, up to 23 hours per day;
- c. medical supplies;
- d. transportation costs;
- e. administrative and operating costs; and
- f. the provider fee.

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If the community home meets the above criteria and the individuals served require that the community home has a licensed nurse at the facility 24 hours per day, seven days per week, the community home may apply for a supplement to the transitional rate. The supplement to the rate shall not exceed \$25.33 per day per individual. The total transitional Medicaid reimbursement rate, including the supplement, shall not exceed \$327.41 per day per individual.

Effective for dates of service on or after October 1, 2014, the transitional Medicaid reimbursement rate shall be increased by \$1.85 of the rate in effect on September 30, 2014.

No payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

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The transitional rate and supplement shall not be subject to the following:

- a. inflationary factors or adjustments;
 - b. rebasing;
 - c. budgetary reductions; or
 - d. other rate adjustments.
2. Quasi-public facilities are reimbursed a facility specific prospective rate based on budgeted costs. Providers submit a projected budget for the state fiscal year beginning July 1. Rates are determined as follows:
- a. Determine each ICF/MR's per diem for the base year beginning July 1.
 - b. Calculate the inflation factor using an average CPI index applied to each facility's per diem for the base year to determine the inflated per diem.
 - c. Calculate the median per diem for the facilities' base year.
 - d. Calculate the facility's routine cost per diem for the SFY beginning July 1 by using the lowest of the budgeted, inflated, or median per diem rates plus any additional allowances.
 - e. Calculate the final approved per diem rate for each facility by adding routine costs plus any "pass through" amounts for ancillary services, provider fees, and grant expenses.
 - f. Providers may request a final rate adjustment subject to submission of supportive documentation and approval by the DHH rate committee.

D. REIMBURSEMENT TO PRIVATE ICF/DD PROVIDERS

Private providers are reimbursed a per diem rate for each resident. Rates are calculated based on information reported on the cost report.

1. Definitions

- a. *Acuity Factor*—an adjustment factor which will modify the direct care portion of the Inventory for Client and Agency Planning (ICAP) rate based on the ICAP level for each resident.

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- b. *Administrative and Operating Costs*—include: in-house and contractual salaries; benefits; taxes for administration and plant operation maintenance staff; utilities; accounting; insurances; maintenance staff; maintenance supplies; laundry and linen; housekeeping; and other administrative type expenditures.
- c. *Capital Costs*—include: depreciation; interest expense on capital assets; leasing expenses; property taxes; and other expenses related to capital assets.
- d. *Care Related Costs*—include in-house and contractual salaries, benefits, taxes, and 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). Care related costs would also include personal items, such as clothing, personal hygiene items (soap, toothpaste, etc), hair grooming, etc.
- e. *Direct Care Costs*—consist of all costs related to the direct care interaction with the patient. *Direct care costs* include:
- in-house and contractual salaries;
 - benefits; and
 - taxes for all positions directly related to patient care, including: medical; nursing; therapeutic and training; ancillary in-house services; and recreational.
- f. *ICAP—Inventory for Client and Agency Planning*. A standardized instrument for assessing adaptive and maladaptive behavior and includes an overall service score. This ICAP service score combines adaptive and maladaptive behavior scores to indicate the overall level of care, supervision or training required.
- g. *ICAP Service Level*—ranges from 1 to 9 and indicates the service need intensity. The lower the score the greater is the client need.
- h. *ICAP Service Score*—indicates the level of service intensity required by an individual, considering both adaptive and maladaptive behavior.

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Note: The relationship between the service level and service score for ICAP support levels is as follows:

ICAP Relationship Graph

ICAP Service Level	ICAP Service Score	ICAP Support Levels
		Pervasive +
1	1-19	Pervasive
2	20-29	Extensive
3	30-39	
4	40-49	Limited
5	50-59	
6	60-69	
7	70-79	Intermittent
8	80-89	
9	90+	

- i. *Index Factor*—this factor will be based on the *Skilled Nursing Home without Capital Market Basket Index* published by Data Resources Incorporated or a comparable index if this index ceases to be published.
- j. *Level of Care(LOC)* – service needs of the client based upon his/her comprehensive functional status.
- k. *Pass through Cost Component*—includes the provider fee.
- l. *Peer Group*—the administrative and operating per diem rate and the capital per diem rate are tiered based on peer group size. Peer groups are as follows:
 - i. 1 - 8 beds;
 - ii. 9 - 15 beds;
 - iii. 16 - 32 beds;
 - iv. 33 or more beds.
- m. *Rate Year*—a one-year period corresponding to the state fiscal year from July 1 through June 30.
- n. *Rebasing*—recalculation of the per diem rate components using the latest available audited or desk reviewed cost reports.
- o. *Support Levels*—describe the levels of support needed by individuals with mental retardation and other developmental disabilities. The five descriptive levels of service intensity using the ICAP assessment are summarized below.

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- 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 - a time-limited specific assignment to supplement required Level of Need services or staff to provide life sustaining complex medical care or to supplement required direct care staff due to dangerous life threatening behavior so serious that it could cause serious physical injury to self or others and requires additional trained support staff to be at "arms length" during waking hours.

2. Cost Reports

Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) are required to file annual cost reports with the Bureau. Cost reports must be prepared in accordance with cost reporting instructions adopted by the Bureau using definitions of allowable and non-allowable costs contained in the Medicare provider reimbursement manual unless other definitions are adopted by the Bureau. Each facility is required to report all reasonable and allowable costs on a regular facility cost report including any supplemental schedules designated by the Bureau. Separate cost reports must be submitted by central/home offices and habilitation programs when costs of those entities are reported on the facility cost report.

Each provider shall submit an annual cost report for the fiscal year ending June 30 within ninety (90) days after the State's fiscal year ends.

Exceptions. Limited exceptions for extensions to the cost report filing requirements will be considered on an individual facility basis upon written request by the provider to the Medicaid director or designee. Providers must attach a statement describing fully the nature of the exception request. The extension must be requested by the normal due date of the cost report.

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Direct Care Floor

A facility wide direct care floor may be enforced upon deficiencies related to direct care staffing requirements noted during the Health Standards Section (HSS) annual review or during a complaint investigation in accordance with LAC 50:I.5501 et seq.

For providers receiving pervasive plus supplements and other client specific adjustments to the rate in accordance with Section 5b., the facility wide direct care floor is established at 94 percent of the per diem direct care payment, the pervasive plus supplement, and other client specific adjustments to the rate. The 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 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.

For facilities for which the direct care floor applies, if the direct care cost the facility incurred on a per diem basis is less than the appropriate facility direct care floor, the facility shall remit to the Bureau the difference between these two amounts times the number of facility Medicaid days paid during the cost reporting period. This remittance shall be payable to the Bureau upon submission of the cost report.

Upon completion of desk reviews or audits, facilities will be notified by the Bureau of any changes in amounts due based on audit or desk review adjustments.

3. Rate Determination

Resident specific per diem rates are calculated based on information reported on the cost report. The rates are based on cost components appropriate for an economic and efficient ICF/ID 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 ICFs/ID.

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. To adjust to budget neutrality, at implementation, the Direct Care component is multiplied by 105% of the previously stated calculation. For rate periods between rebasing, the rates will be trended forward using the index factor.

For dates of service on or after October 1, 2005 a resident's per diem will be the sum of:

- a. direct care per diem rate;
- b. care related per diem rate;
- c. administrative and operating per diem rate;
- d. capital rate; and
- e. provider fee.

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.

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Determination of Rate Components

- a. 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:

Median Cost. The direct care per diem median cost for each ICF/MR 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 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 shall be 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:

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

Direct Care Worker Wage Enhancement. For dates of service on or after February 9, 2007, the direct care reimbursement to ICF-MR providers shall include a direct care service worker wage enhancement incentive in the amount of \$2 per hour. The wage enhancement will be added on to the current ICAP rate methodology as follows:

- i. Per diem rates for recipients residing in 1 - 8 bed facilities will be increased by \$16.00;
- ii. Per diem rates for recipients residing in 9 - 16 bed facilities will be increased by \$14.93; and
- iii. Per diem rates for recipients residing in 16+ bed facilities will be increased by \$8.00.

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- b. 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/MR 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.

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.

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- c. 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 (50th 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.

- d. 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 Cost. The capital per diem median cost for each ICF/MR 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.

- e. The provider fee shall be calculated by the Department in accordance with state and federal rules.

Peer Groups

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The rates for the 1-8 bed peer group shall be set on costs in accordance with provisions in D.3. above. The reimbursement rates for peer groups of larger facilities will also be set in accordance with the provisions in D.3. above; however the rates will be limited as follows:

Reimbursement rates for the 9 – 15 bed peer group will be limited to 95 percent of the 1-8 bed peer group reimbursement rates.

Reimbursement rates for the 16 – 32 bed peer group will be limited to 95 percent of the 9-15 bed peer group reimbursement rates.

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PAYMENT FOR MEDICAL AND REMEDIAL CARE AND SERVICES

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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/DD 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/DD) shall be reduced by 1.5 percent of the per diem rates on file as of June 30, 2012.

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 DHH 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 DHH 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.

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.

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6. ICAP Requirements

An ICAP must be completed for each recipient of ICF/MR services upon admission and while residing in an ICF/MR 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 the 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 DHH and its contracted agents. The reviews of ICAP submissions include, but are not limited to:

- reviews when statistically significant changes occur within ICAP submission(s);
- random selections of ICAP submissions;

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desk reviews of a sample of ICAP submissions; and
on-site field review of ICAPs.

ICAP Review Committee

The ICAP Review Committee shall represent DHH should a provider request an informal reconsideration regarding the department's determination. The committee shall make final determination on any ICAP level of care changes prior to the appeals process. 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.

8. Audits.

All providers who elect to participate in the Medicaid Program shall be subject to financial and compliance audits by state and federal regulators or their designees. Audit selection for the Department shall be at the discretion of DHH.

In addition to the exclusions and adjustments made during desk reviews and on-site audits, DHH may exclude or adjust certain expenses in the cost report data base in order to base rates on the reasonable and necessary costs that an economical and efficient provider must incur.

The facility shall retain such records or files as required by DHH and shall have them available for inspection for five years from the date of service or until all audit exceptions are resolved, whichever period is longer.

9. Exclusions from the database.

Providers with disclaimed audits and providers with cost reports for other than a 12-month period will be excluded from the database used to calculate the rates.

Providers who do not submit ICAP scores will be paid at the intermittent level until receipt of ICAP scores.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(a) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN - ARE DESCRIBED AS FOLLOWS:

12. QUALIFYING LOSS REVIEW PROCESS

A. Definitions

Providers may seek an interim adjustment to the per diem rate through the Qualifying Loss Review process. Qualifying loss in this context refers to that estimated amount by which the facility's cost for the state fiscal year exceeds the anticipated Title XIX reimbursement. Cost in this context means a facility's documented allowable cost incurred in providing covered services to Title XIX Medicaid recipients, as calculated in the relevant definitions governing cost reporting.

B. Permissible Basis

Consideration for Qualifying Loss Review is available only if one of the following conditions exists:

1. The facility's prospective rate is less than ninety-five per cent (95%) of the estimated costs (including 5% return on investment) to be incurred by the facility in providing Medicaid services in compliance with the applicable state and federal laws related to quality and safety standards during the period that rate is in effect.
2. Rate-setting methodologies or principles of reimbursement established under the reimbursement plan were incorrectly applied; or
3. Incorrect data or erroneous calculations were used.

C. Basis Not Allowable

The following matters are not subject to a qualifying loss review:

1. The methodology used to establish the per diem;
2. The use of audited and/or desk reviews to determine allowable costs;
3. The economic indicators used in the rate setting methodology;

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- 4. Rate adjustments related to changes in federal or state laws, rules or regulations (e.g., minimum wage adjustments).
- 5. Incorrectly reported cost which occurred at least three years prior to the effective rate period.

D. Basis For Rate Adjustment

1. Factors Considered

Substantiating evidence of the following are required:

- a. The facility will incur a qualifying loss;
- b. The loss will impair a facility's ability to provide services in accordance with state and federal health and safety standards;
- c. The facility has satisfactorily demonstrated that it has taken all appropriate steps to eliminate management practices resulting in unnecessary expenditures; and
- d. The facility has demonstrated that its unreimbursed costs are generated by factors generally not shared by other facilities in the facility's bed size LOC.

2. Determination To Award Relief

In determining whether to award additional reimbursement to a facility that has made the showing required, one or more of the following factors may be considered:

- a. The facility has demonstrated that its unreimbursed costs are generated by factors generally not shared by other facilities in the facility's bed size LOC. Such factors may include, but are not limited to, extraordinary circumstances beyond the control of the facility; or

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(a) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN - ARE DESCRIBED AS FOLLOWS:

- b. The department may consider, and may require the facility to provide financial data, including but not limited to financial ratio data indicative of the facility's performance quality in particular areas of operations; or
- c. The department shall consider whether the facility has taken every reasonable action to contain costs on a facility wide basis. In making such a determination the director may require the facility to provide audited cost data or other quantitative data and information about actions that the facility has taken to contain costs.

3. Calculation of Rate Adjustment

The adjustment is calculated as an annual amount equal to the difference between the requesting facility's anticipated programmatic costs and the programmatic cost portion of the class-wide fixed rate for the state fiscal year. The rate adjustment is paid as monthly add-on to the class-wide fixed rate. No additional reimbursement will be provided if actual costs exceed the original anticipated costs, and the facility will be required to repay the amount in excess of actual costs.

E. Scope Of Decisions

Decisions to recognize omitted, additional or increased costs incurred by any facility; to adjust the facility rates; or to otherwise award additional reimbursement to any facility under the provisions of section C.12. shall not result in any change in the bed size LOC per diem for the remaining facilities in the bed size LOC, except the Department may adjust the per diem if the facilities receiving adjustments comprise over ten per cent (10%) of total utilization for that bed size LOC based on the latest audited and/or desk reviewed cost reports.

All facilities receiving a qualified loss adjustment shall be cost settled up to but not over the amount of their class-wide fixed rate plus qualifying loss adjustment. Should a single facility that is an entity under common ownership or control with another facility or groups of facilities be awarded relief, all facilities under common ownership or control with the facility awarded relief shall be subject to audit and cost settlement. Facilities under common ownership or control with facilities receiving qualifying loss adjustment but not themselves receiving qualifying loss adjustment shall be cost settled at an amount up to, but not more than, the amount of the class-wide fixed rate.

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STATE OF LOUISIANA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(a) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN - ARE DESCRIBED AS FOLLOWS:

13. Complex Care Reimbursements

- A. Effective for dates of service on or after October 1, 2014, private (non-state) intermediate care facilities for persons with intellectual disabilities may receive an add-on payment to the per diem rate for providing complex care to Medicaid recipients who require such services. The add-on rate adjustment shall be a flat fee amount and may consist of payment for any one of the following components:
1. equipment only;
 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.
- B. Private (non-state) owned ICFs/ID may qualify for an add-on rate for recipients 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.
- C. 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.
 - a. Qualifying conditions for complex care must include at least one of the following as documented on the complex support need screening tool:
 - i. significant physical and nutritional needs requiring full assistance with nutrition, mobility, and activities of daily living;
 - ii. complex medical needs/medically fragile; or
 - iii. complex behavioral/mental health needs.
- D. Enhanced Supports. Enhanced supports must be provided and verified with supporting documentation to qualify for the add-on payment. This includes:
1. endorsement and supporting documentation indicating the need for additional direct service worker resources;

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905(a) OF THE ACT THAT ARE INCLUDED IN THE PROGRAM UNDER THE PLAN - ARE DESCRIBED AS FOLLOWS:

2. endorsement and supporting documentation indicating the need for additional nursing resources; or
 3. endorsement and supporting documentation indicating the need for enhanced equipment resources (beyond basic equipment such as wheelchairs and grab bars).
- E. One of the following admission requirements must be met in order to qualify for the add-on payment:
1. the recipient has been admitted to the facility for more than 30 days with supporting documentation of necessity and provision of enhanced supports; or
 2. the recipient is transitioning from another similar agency with supporting documentation of necessity and provision of enhanced supports.
- F. All of the following criteria will apply for continued evaluation and payment for complex care.
1. Recipients receiving enhanced rates will be included in annual surveys to ensure continuation of supports and review of individual outcomes.
 2. Fiscal analysis and reporting will be required annually.
 3. The provider will be required to report on the following outcomes:
 - a. hospital admissions and diagnosis/reasons for admission;
 - b. emergency room visits and diagnosis/reasons for admission;
 - c. major injuries;
 - d. falls; and
 - e. behavioral incidents.

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