Intermediate Care Facilities for Individuals with an Intellectual Disability Frequently Asked Questions

Update: August 2023

1. **Question: What are the audit principles and statutory requirements?**

Response: From Sec. 17b-99a, CGS (Audits of long-term care facilities):

> The Commissioner of Social Services shall conduct any audit of a licensed chronic and convalescent nursing home, chronic disease hospital associated with a chronic and convalescent nursing home, a rest home with nursing supervision, a licensed residential care home, as defined in section 19a-490, and a residential facility for persons with intellectual disability which is licensed pursuant to section 17a-227 and certified to participate in the Medicaid program as an intermediate care facility for individuals with intellectual disabilities in accordance with the provisions of this section.

The Connecticut Medicaid Provider Agreement permits the Department to conduct reviews and audit of any and all information related to Medicaid payment. A Medicaid provider's legal obligations are governed by applicable federal and state law. Audit protocols do not encompass all the current requirements for payment of Medicaid claims for a particular category of service or provider type and, therefore, are not a substitute for a review of the statutory and regulatory law.

For more information on audit protocol and principles please visit the Department's website: https://portal.ct.gov/DSS/Quality-Assurance/Audit-Protocols

2. **Question: What are general permissible expenditures allowed by stabilization payment?**

Response: Generally, funds were issued for the purpose of general operations and employee wage support. Funding is flexible and can be used to meet a broad range of needs, as long as those expenditures comply with DSS' cost principles.

3. **Question: If we received a payment on 6/27 for a facility that closed in June 2023, will this payment need to be returned?**

Response: Payments were to be issued to facilities that had residents living there as of June 30, 2023 and were determined based on their proportion of Medicaid expenditures incurred between July 1, 2022 and December 31, 2022. Any provider that believes they received a payment in error should contact the Department directly.

4. **Question: How will the Department recognize changing costs as the industry experiences changes over the coming years? Will the Department give consideration to changes in staffing costs or increases in vendor costs?**

Response: ICF rates are cost based Medicaid rates set in accordance with state statute and regulation. Changes in costs will be recognized over the next three years pursuant to state statute which gives the Department the authority to rebase rates for the next three cost years. Providers are encouraged to fully

complete and timely file their cost reports so DSS can accurately capture reported expenses during the rebasing period.

5. Question: What are examples of direct care costs?

Response: Medicaid rates are established pursuant to Section 17b-340 and 17-311, CGS. In accordance with statute and Department regulations, allowable Medicaid costs may be categorized into five cost groups for rate computation purposes. Costs are reported to the Department annually and reported expenditures are desk reviewed and categorized into five cost groups:

- Direct - Nursing and nurse aide personnel salaries, related fringe benefits and nursing pool costs.
- Indirect - Professional fees, dietary, housekeeping, laundry personnel costs and expenses and supplies related to patient care.
- Administrative and General - Maintenance and plant operation expenses, and salaries and related fringe benefits for administrative and maintenance personnel.
- Property (Fair Rent) - A fair rental value allowance is calculated to yield a constant amount each year in lieu of interest and depreciation costs.
- Capital Related - Property taxes, insurance expenses, moveable equipment leases and moveable equipment depreciation.

6. Question: Are there limitation applied to cost categories?

Response: Rates are calculated in accordance with Sec. 17-311-52 of the regulations of Connecticut state agencies (Computation of per diem reimbursement rates).

7. Question: Is there a time period when the stabilization payment needs to be spent/recognized as revenue? Will unused portions be taken back and if so, when?

Response: Given that one-time stabilization funds were issued for the purpose of general operations and employee wage support, it is not expected that there will be unused portions, though funds should be expended by the end of the three-year rebasing period. These funds will not be specifically targeted for audit.

8. Question: Why is the minimum rate of $501 disappearing in 2024?

Response: The minimum per diem rate is established under statute and does not sunset until SFY 2026. The minimum rate of $501 was intended to help those facilities whose rates were artificially low due to pandemic-related issues, such as staffing, and due to the length of time since the rates were last rebased. With the rebasing over the three-year period, facilities will be able to update their cost reports to better reflect their current costs. By year three of the rebasing, it is expected rates will better align with a facility's costs.