

## DEPARTMENT OF SOCIAL SERVICES

### Special Notice of Proposed Medicaid State Plan Amendment 13-028

Date: August 21, 2013

On May 28, 2013, the Department issued public notice of its intent to submit a Medicaid State Plan Amendment (SPA) to revise payment rates for private intermediate care facilities for individuals with intellectual disabilities.

**The Department has extended the time frame for the submission of comments to September 6, 2013.**

Please mail or e-mail your comments to: Christopher LaVigne, Office of Reimbursement & Certificate of Need, Department of Social Services, 25 Sigourney Street, Hartford, CT 06106-5033, Telephone: (860) 424-5719, Fax: (860) 424-4812, Email: [Christopher.Lavigne@ct.gov](mailto:Christopher.Lavigne@ct.gov). Please reference the SPA TN # 13-028 Payments to Private ICF/MRs. Please find below the original public notice followed by the State Plan language concerning SPA 13-028.

#### **CT Law Journal – May 28, 2013 Notice**

The State of Connecticut Department of Social Services (the “Department”) proposes to submit an amendment to the Medicaid State Plan to the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services. The proposed Medicaid State Plan Amendment (SPA) will revise payment rates for private intermediate care facilities for the mentally retarded (ICF/MRs).

#### Changes to Medicaid State Plan

Based upon the most recent version of the draft Legislative Budget for the State Fiscal Year 2014 and State Fiscal Year 2015 biennium and actions to date by the General Assembly, it is anticipated that the Medicaid State Plan will be amended to include the rebasing of rates and the implementation of any rate increases or decreases. While implementing legislation is still pending in the General Assembly, federal regulations require the Department to submit public notice at this time.

#### Fiscal Information – Estimated Annual Change to Medicaid Expenditures

Based upon preliminary estimates, it is anticipated that annual aggregate expenditures for payments to private intermediate care facilities for the mentally retarded will decrease by approximately \$1.1 million for State Fiscal Year 2014 and \$1.5 million for State Fiscal Year 2015.

#### Additional Information

In accordance with federal requirements governing the Medicaid program, upon request, the Department will provide copies of the proposed amendment to the Medicaid State Plan. In addition, copies of the proposed amendment may be obtained at each of the Department’s regional offices and on the Department’s web site: <http://www.ct.gov/dss>. Go to “Publications” and then to “Updates”.

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**I. General Description of Payment Methodology**

**A. Overview.**

This document describes the methods and standards used to establish Medicaid rates of payment to Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) effective July 1, 2013.

**B. Chief Components.**

The payment method describes payment rate calculations for ICF/IID services. Payment rates are calculated based on reported allowable costs that are divided into five cost components: direct costs, indirect costs, administrative and general costs, capital-related costs, and fair rent.

**II. Cost Reporting Requirements and Cost Finding**

**A. Required Annual Report.**

Each ICF/IID for which rates are determined must complete a cost report designated as the “Annual Report of Long Term Care Facilities.” The annual report is used to provide detailed cost information for each year for the cost year ending September 30.

**B. Filing Date.**

The required completed annual report for each cost year must be received no later than December 31 or the first full business day after the New Year, if so designated.

**C. Filing Requirements.**

When filing the annual report, two notarized hard copies bearing the original signatures of the administrator, owner and independent certified public accountant must be filed. Submission of the Annual Report electronically on a CD or by other means designated by the Department is recommended, but not required. Software for completion of the annual report is provided by the Department. The format and design of alternative software must be submitted for approval by the Department at least sixty (60) days prior to the cost report due date.

**D. Filing Extension.**

No filing extensions are granted.

**E. Late filing.**

The rate in effect for a facility which fails to report on or before the filing date may be reduced by an amount not to exceed ten percent of such rate.

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**F. Failure to Submit Annual Report or Filing of an Incomplete Submission.**

Failure to submit an annual report in a complete and timely manner may result in not promulgating an individual cost-related rate for such facility for the next rate year beginning July 1. For such facilities, the Department may authorize a rate comparable to the lowest rate paid to a facility for the same level of care. Incomplete annual reports are not accepted.

**G. Amendment of Cost Report Post Filing.**

Revised or corrected pages of the cost report must be marked as “Amended” and changes must be highlighted. In order to be accepted, amended pages must include the Administrator’s and Owner’s Certifications and an explanation of the reason for any change or changes to the original filing. Amended cost report pages will not be accepted after the rate has been calculated and issued by the Department.

**H. Appeals.**

A provider aggrieved by any decision of the Department may obtain a hearing on all items of grievance, not more than ten days after the date of the Department’s written notice thereof, by written request to the Department. A hearing is held by the Commissioner or the Commissioner’s designee, provided a written request is filed not more than ten days after the date of the Department’s letter to the ICF/IID designating the rate and a detailed written description of all such items is filed not more than ninety days after the date of the Department’s letter to the ICF/IID designating the rate.

**I. Commissioner’s Letter**

An annual letter from the Department concerning filing of the cost report is sent to each facility. The letter contains the website address needed to access cost report software, preparation instructions, salary limitations, and a completion check list. In addition the letter includes the filing due date, penalty information for late filing or failure to file, contact information, instructions on how to amend the cost report post filing, and advisory notices.

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**III. Methods and Standards Used to Determine Payment Rates.**

**A. Cost Based Prospective Per Diem Rates.**

**1. Rebasing.**

Costs are rebased annually but can be deferred not to exceed every four years, as determined by the Commissioner.

**2. Allowable Costs.**

Individual cost based prospective per diem payment rates for ICF/IIDs are derived from cost information provided by each facility in the annual report. ICF/IID allowable costs are divided into the following five cost components: direct care, indirect care, administrative and general, capital related, and property components.

**3. Inflation Update.**

Allowable operating costs, excluding fair rent, are inflated using the Regional Data Resources Incorporated McGraw-Hill Health Care Costs: Consumer Price Index (all urban). The inflation index is computed to reflect inflation between the mid-point of the cost year through the midpoint of the rate year.

**4. Minimum Occupancy and Imputed Days.**

For purposes of computing minimum allowable patient days utilization of a facility's certified beds is a minimum of ninety-five per cent of capacity. New facilities and facilities which are certified for additional beds may be permitted a lower occupancy rate for the first three months of operation after the effective date of licensure.

**B. Direct Costs.**

1. Direct costs include salaries for nursing personnel, related fringe benefits, and nursing pool costs.
2. Allowable direct care cost component limits are established for ICF/IID.
3. For each licensure level allowable direct cost component limits are established for two geographic peer groupings of facilities in recognition of higher area wages. One peer group is comprised of facilities located in Fairfield County. The other peer grouping is comprised of facilities located in all other counties.
4. The maximum for direct costs is equal to one hundred thirty five per cent of the median allowable cost of that peer grouping.

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**C. Indirect Costs.**

1. Indirect costs include professional fees associated with resident care, dietary expenses, housekeeping expenses, laundry expenses, supplies related to patient care, salaries for indirect care personnel and related fringe benefits.
2. The maximum for indirect costs is equal to one hundred fifteen per cent of the median allowable cost.
3. A cost efficiency adjustment is provided if the indirect costs are below the state-wide median costs. The cost efficiency adjustment equals twenty-five per cent of the difference between allowable reported costs and the applicable median allowable cost.

**D. Administrative and General Costs.**

1. Administrative and general costs include maintenance and operation of plant expenses, salaries for administrative and maintenance personnel and related fringe benefits.
2. The maximum for administrative and general costs is equal to one hundred per cent of the median allowable cost.
3. A cost efficiency adjustment is provided if the administrative and general costs are below the state-wide median costs. The cost efficiency adjustment equals twenty-five per cent of the difference between allowable reported costs and the applicable median allowable cost.

**E. Capital Related Costs.**

Capital related costs include property taxes, insurance expenses, equipment leases and movable equipment depreciation.

**F. Fair Rental Value Allowance.**

Fair rental value allowance is computed in lieu of interest on mortgages, other property financing costs, depreciation on buildings and non-moveable and rental charges. Fair rental value allowance is a rental allowance of the use of land and real property, which includes buildings, building and land improvements, and non-moveable equipment related to resident care. The allowance is computed in the same manner whether the facility is owned or leased and whether the facility is operated by an individual owner, partners, or corporation. Non-profit facilities receive either the lower of allowable fair rent or actual interest and depreciation plus certain other disallowed costs, which include the following: direct, indirect, and administrative and general costs in excess of cost component limits; costs in excess of salary limits; effect of return on equity; salaries and fees that are not allowable costs under the rate; and professional association dues.

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**1. Land.**

- a. The annual fair rental value allowance for the use of land is determined by multiplying the base value of the land by a rate of return which is equal to one-third of the Medicare rate of return for the cost year, but not more than four percent nor less than two and one-half percent.
- b. The base value of the land of a facility first used as a ICF/IID is the actual cost of the land consisting of the purchase price and the cost of grading, filling and site preparation.
- c. The base value of land will not be adjusted due to a change in ownership.

**2. Real Property.**

In accordance with the American Hospital Association Guide for Estimated Useful Lives, real property other than land consists of buildings and building improvements, non-moveable equipment (all equipment attached to buildings and considered to be real property as distinguished from personal property), and land improvements (parking lots, driveways, sidewalks, sewage systems, walls and pump houses). The fair rental value allowance is calculated to yield a constant amount each year in lieu of interest and depreciation costs, such allowance for the use of real property other than land is determined by amortizing the base value of property over its remaining useful life and applying a rate of return on the unamortized base value.

**3. Minimum Fair Rent.**

A facility with allowable fair rent less than the twenty-fifth percentile of the state-wide allowable fair rent is reimbursed as having allowable fair rent equal to the twenty-fifth percentile of the state-wide allowable fair rent. Minimum fair rent may be the basis upon which reimbursement associate with improvements to real property is added.

**4. Certificate of Need.**

A certificate of need is required for fair rent increases for capital expenditure exceeding one million dollars and which increases facility square footage by more than five thousand square feet or five per cent of the existing square footage, whichever is greater, and for capital expenditure exceeding two million dollars.

**5. Return on Equity.**

- a. Proprietary facilities are allowed a return on equity which is determined by multiplying the Medicare rate of return for the cost year by the average current equity for the cost year and the average non-current equity for the cost year.
- b. For facilities which submit an annual report for less than a full year of operation, the return on equity is adjusted in proportion to the length of the annual report period.

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**6. Depreciation and Amortization.**

Expenditures for fixed assets and moveable equipment, which are greater than \$2,500 must be capitalized and depreciated or amortized over the useful life of the asset in accordance with the American Hospital Association Guide for Estimated Useful Lives. Assets in excess of \$1,000, but less than \$2,500 may be capitalized, provided such accounting method is consistent with the organization's written capitalization policy.

**7. Certificate of Need Authorization for Capital Expenditure.**

Certificate of Need authorization is required for the following:

- a. capital expenditure in excess of one million dollars, which increases facility square footage by more than five thousand square feet or five percent of the existing square footage, whichever is greater;
- b. capital expenditure exceeding two million dollars; or
- c. the acquisition of major medical equipment in excess of four hundred thousand dollars, including the leasing of equipment or space.

**IV. Salary Limits**

There are allowable salary limits for administrators, assistant administrators, dieticians and physicians. In addition there are allowable salary limits for the director of nurses and all other professional and technical personnel who are related to the owner or related to persons in non-profit facilities who exercise the equivalent of proprietorship or management function. The allowable salary limits for ensuing years are to be inflated annually from the allowable salary limits used in 2013 using the most recently available version of the CMS Nursing Home without Capital Market Basket Index from the mid-point of the 2013 Medicaid Rate Year to the mid-point of the current Medicaid rate year as follows:

TN # 13-028  
Supersedes  
TN # New

Approval Date \_\_\_\_\_

Effective Date 7/1/2013

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<b>Rate Effective Date</b> January 1, Year 1 April 1, Year 1 July 1, Year 1 October 1, Year 1	<b>Midpoint Quarter</b> July 1, Year 1 October 1, Year 1 January 1, Year 2 April 1, Year 2.
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Allowable salary limits for subsequent years are determined by applying the resulting inflation adjustment to the allowable salary limits for the preceding year. The schedule of salary limits is based on full time salaries.

<b>Salary Limitations for Cost Year 2013</b>					
		<b>Number of Beds</b>	<b>Allowable</b>	<b>Add Per Bed</b>	<b>Maximum</b>
<b>Administrator</b>	<b>Within LICENSURE Category</b>		<b>Salary Limits</b>	<b>Increment</b>	<b>Salary Limits</b>
	<u>Residential Care Homes</u>				
		1-60	\$47,458	\$176	\$58,018
		61-120	58,018	192	69,538
	<u>Other Community Group Homes</u>				
		1-60	\$38,020	\$176	\$48,580
		61-120	48,580	192	60,100
		121-Over	60,100	151	69,322
	<u>Rest Home with Nursing Supervision</u>				
		1-30	\$38,020	\$206	\$44,200
		31-60	44,200	448	57,640
		61-120	57,640	208	70,120
		121-180	70,120	212	82,840
		181-Over	82,840	208	95,538
	<u>Chronic &amp; Convalescent Nursing Home &amp; Multi-Level Facilities</u>				
		1-60	\$40,945	\$450	\$67,945
		61-120	67,945	335	88,045
		121-180	88,045	255	103,345
		181-Over	103,345	212	116,114

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<b><u>Assistant Administrator</u></b>					
For facilities over 99 certified beds, one Assistant Administrator (in addition to the Administrator) may be allowed for each 100 beds at a salary up to a maximum of 70% of the allowable salary paid to the Administrator.					
<b><u>Director of Nurses who are related to the Owner(s)</u></b>					
		<b>Number of Beds</b>	<b>Allowable</b>	<b>Add Per Bed</b>	<b>Maximum</b>
		<b><u>Within LICENSURE Category</u></b>	<b><u>Salary Limits</u></b>	<b><u>Increment</u></b>	<b><u>Salary Limits</u></b>
		1-60	\$28,597	\$319	\$47,737
		61-120	47,737	237	61,957
		121-180	61,957	181	72,817
		181-Over	72,817	148	81,239
<b><u>Dieticians</u></b>		Per Hour	\$45.08		
<b><u>Physicians</u></b>		Per Hour	\$153.78		
<b><u>All other Professional / Technical Personnel who are related to the Owner(s):</u></b>					
<b><u>Residential Care Homes</u></b>					
		<i>Salary for full time work</i>	\$37,578		
<b><u>All Other Licensure Levels</u></b>					
		<i>Salary for full time work</i>	\$33,532		

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**V. Management Service Fees.**

**A. Related Parties.**

Management fees paid to related parties are recognized only to the extent of the actual cost to the related party of providing necessary services related to patient care.

**B. Unrelated Parties.**

Fees paid to outside organizations for management services are allowed for inclusion in the computation of the per diem reimbursement rate, provided that such costs are paid under arms-length arrangements to unrelated parties and are approved by the Department.

**A. Approval.**

Arrangements for management services are reviewed as to their reasonableness in relation to the size of the facility and the complexity of its operating structure, as to their necessity for the effective administration of the facility's operations.

**VI. Unallowable Costs.**

**A. Costs not Reasonable and Directly Related to Provision of Services**

All costs included in the computation of the per diem reimbursement rate must be reasonable and directly related to the provision of services necessary for patient care. In addition to those costs specifically disallowed pursuant to the Medicare statutes and regulations as modified by these regulations, items excluded from the calculation of the rate include, but are not limited to:

1. duplications of functions or services;
2. expenditures made for the protection, enhancement, or promotion of a provider's interests;
3. educational expenditures to colleges or universities for tuition and related costs for owners or employees;
4. directors' fees;
5. expenditures made for the personal comfort, convenience or transportation of owners or employees;
6. travel for purposes of attending conferences or seminars outside of the continental United States. Other out-of-state travel to attend bona fide professional seminars must be limited to no more than one representative from the participating facility and the total dollars expended must meet the Medicare definition of reasonableness;
7. outpatient services, day care services and meals-on-wheels;
8. costs of residences which are not certified as long term care facilities;
9. bad debts;

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10. advertising except for help wanted ads;
11. expenditures made for salaries, fringe benefits or any type of reimbursement to or for any person who is convicted in any state or federal court of a crime involving fraud in the Medicare program or Medicaid program or aid to families with dependent children program or state supplement to the federal supplemental security income program or any federal or state energy assistance program or general assistance program and is under a resultant termination or suspension from participation in any of said programs.

**B. Costs of Reimbursement Rate Adjustments Claims.**

Legal, accounting and consultant services, and related costs incurred in connection with hearings, arbitration or judicial proceedings pertaining to reimbursement rate adjustment are not allowable. If it is concluded that the facility's request for reimbursement rate adjustment constitutes a valid claim, then the reasonable aggregate amount of legal, accounting and consultant services, and related costs are allowable.

**C. Disallowance of Interest Expense Exceptions.**

1. For proprietary facilities, any interest expense on any form of indebtedness is not allowed as reimbursable expense, since proprietary facilities are allowed a fair rental allowance for the use of land, buildings, and non-movable equipment and a return on equity for the use of all other assets related to the provision of current patient care.
2. For non-profit facilities, only an interest expense required to obtain necessary working capital is allowed as a reimbursable expense. Any other interest expense is disallowed, since non-profit facilities are allowed a fair rental allowance for the use of land, buildings, and non-movable equipment.
3. The disallowance of interest expense described above does not preclude capitalization of interest during the period of construction of a new facility or an addition to an existing facility and the inclusion of such capitalized interest in the cost of construction.

**VII. Change of Ownership.**

**Recoupment of Medicaid Overpayments.**

Whenever a facility has received past Medicaid overpayments, the department may recoup the amount of such Medicaid overpayments from the monthly Medicaid payments to the facility regardless of any intervening change in ownership.

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Supersedes

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**VIII. Interim Rates.**

**A. Newly Constructed Facilities.**

Newly constructed facilities receive an interim per diem rate of payment for each level of care computed on the basis of budgetary data submitted.

**B. Newly Acquired Facilities.**

Newly acquired facilities receive an interim per diem rate of payment for each level of care based on the existing rate adjusted to reflect any changes in property values. If substantive changes in operation have been affected by the new owners that materially changes operating costs, additional adjustments to the existing rates may be made to the extent such changes in operations and related costs are specifically identified and documented by the facility.

**C. Changes in Level of Care or Bed Capacity.**

An interim per diem rate may be authorized for a facility which has undergone changes in level of care or significant changes in licensed bed capacity mandated or approved by the Department of Public Health and the Department of Social Services.

**D. Avoidance of Substantial Financial Deterioration**

An interim rate increase for an ICF/IID may be issued if the Department determines that the increase is necessary to avoid the filing of a petition for relief under Title 11 of the United States Code, if receivership is imposed, or if substantial deterioration of the facility's financial condition that may be expected to adversely affect resident care and the continued operation of the facility. It must be determined that the continued operation of the facility is in the best interest of the state

**E. Criteria.**

When reviewing a rate increase request, the following minimum criteria are considered:

1. existing intermediate care facilities for individuals with intellectual disability utilization in the area and projected bed need;
2. physical plant long-term viability and the ability of the owner or purchaser to implement any necessary property improvements;
3. licensure and certification compliance history;
4. reasonableness of actual and projected expenses; and
5. the ability of the facility to meet wage and benefit costs.

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**F. Interim Rate Revision.**

An interim per diem rate may be revised at any time based on additional information which may become available. The interim rate remains in effect until the first of the following occurs:

1. for newly constructed facilities, a per diem rate is computed on the basis of an annual report for a full cost year in which the facility achieved ninety-five percent (95%) occupancy of its certified beds; or
2. a per diem rate is computed on the basis of the facility's second annual report for a full cost year.

**G. Interim Rate Replacement.**

Interim rates are replaced by revised per diem rates computed on the basis of actual costs which are allowable as defined in this section of the State Plan, and minimum allowable patient days (ninety-five percent utilization except for new facilities and facilities which are certified for additional beds which may be permitted a lower occupancy rate for the first three months of operation after the effective date of licensure) for the period in which the interim rates were in effect. Proper retroactive adjustments, in favor of the provider or the state, shall be made to all amounts paid on the basis of interim rates.

**H. Interim Rate Limit.**

No interim rate is to be increased in excess of one hundred fifteen per cent of the median rate for the facility's peer grouping, unless recommended by the Commissioner and approved by the Secretary of the Office of Policy and Management after consultation with the Commissioner

**IX. Special Conditions.****A. Increase or Decrease of More than Ten Beds.**

Based upon review of a facility's costs, direct care staff to patient ratio and any other related information, a facility's rate may be revised for any increases or decreases to total licensed capacity of more than ten beds.

**B. Health and Safety.**

Extraordinary and unanticipated costs of providing services which were incurred to avoid an immediate negative impact on the health and safety of residents may be allowed.

**C. Additional ICF/IID Beds**

A Certificate of Need is required for authorization to relocate beds from one ICF/IID to another and for reimbursement of project related capital costs.

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**D. Minimum Wage Increases.**

If legislative action increases the minimum wage rate for labor, then intermediate care facilities for individuals with intellectual disabilities are eligible to receive separate reimbursement for the portion of the resulting increase in wage costs for employees affected applicable to Medicaid residents.

**E. Limitations on Per Diem Rates.**

Per diem rates under the Medicaid program shall not exceed the rate of payment for self-pay persons, or the general ceiling for Medicare.

**F. Related Party Principle.**

The related party principle as adopted by the Medicare program is accepted as a minimum standard.

**G. Reimbursement for Changes in Federal or State Requirements.**

If changes in federal or state laws, regulations, or standards related to the provision of patient care results in increased costs or expenditures, then facilities are eligible for reimbursement of reasonable costs applicable to Medicaid residents through either separate reimbursement or rate adjustment, as appropriate.

**X. Reimbursement for Reservation of Beds.**

**A. Hospital Bed Hold**

**1. First Seven Days.**

A facility is reimbursed for reserving the bed of a resident who is hospitalized for a maximum of seven days including the admission date of hospitalization, if the ICF/IID documents that it has a vacancy rate of not more than three beds or three per cent of licensed capacity, whichever is greater and the hospital fails to confirm that the person would be unable to return to the ICF/IID within fifteen days of the date of hospitalization.

**2. Maximum of Eight Additional Days.**

The ICF/IID shall be reimbursed for a maximum of eight additional days provided that on the seventh day of the person's hospital stay, the ICF/IID has a vacancy rate that is not more than three beds or three per cent of licensed capacity, whichever is greater, and the hospital does not indicate that the person will be unable to return to the ICF/IID within fifteen days after the date of hospitalization.

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**B. Home Leave Bed Hold.**

A facility is reimbursed for reserving the bed of a resident who is absent for up to thirty six days of home leave if on the day of such an absence the facility documents that it has a vacancy rate of not more than four beds or four per cent of licensed capacity, whichever is greater.

**XI. Desk Review and Field Audits.**

**A. Computation of Rates**

Medicaid per diem rates are determined by desk review of the submitted annual reports which are verified and authenticated by field audit procedures which are approved by the United States Department of Health and Human Services. Facilities are generally audited on a biennial basis. The audit cycle may be changed based upon audit experience. Re-computation of a rate is based upon field audit adjustments or otherwise and is retroactive to the applicable period. Retroactive re-computation replaces the originally determined annual Medicaid per diem rate and does not constitute a new annual Medicaid per diem rate.

**B. Medicaid Overpayments**

The department recoups Medicaid overpayments as soon as possible from the department's monthly Medicaid payments to the facility. Requested re-hearings are afforded to a facility as soon as practicable after commencement of recoupment of past Medicaid overpayments.

**C. Recoupment Schedule**

The Department determines a schedule of amounts to be recouped from the facility's monthly Medicaid payments after consideration of the amount of the indebtedness, the objective of completion of total recoupment of past Medicaid overpayments as soon as possible, the cash flow of the facility, and other factors brought to the attention of the department by the facility which affect the provider's ability to function after recoupment.

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**XII. State Fiscal Year 2014 and 2015 State Legislative Changes**

**A. Intermediate Care Facilities for Individuals with Intellectual Disabilities**

For the period of July 1, 2013 through August 30, 2013, rates in effect for the period ending June 30, 2013 shall remain in effect, except for any facility that would have been issued a lower rate due to interim rate status or agreement with the department shall be issued such lower rate. Rates for this period, however, may be adjusted to reflect adjustments in fair rent placed into service during the 2012 cost report year.

For the period of September 1, 2013 through June 30, 2015, the Commissioner of Social Services shall implement a 2.0 per cent rate decrease, except for any facility that would have been issued a lower rate due to interim rate status or agreement with the department, shall be issued such lower rate. For the period of July 1, 2014 through June 30, 2015, rates may be adjusted to reflect adjustments in fair rent placed into service during the 2013 cost report year.

TN # 13-028

Supersedes

TN # 12-020

Approval Date \_\_\_\_\_

Effective Date 7/1/2013