ICF Stabilization Payments & Multiyear Rebasing

July 2023

AGENDA

- ICF Stabilization Payment ($5.6 million)
  - Overview, Background
  - Implementation
- Medicaid Reimbursement Principles
- Multi-year ICF Rebasing
  - Methodology
  - Phased Implementation Steps
  - Sample Calculation
- Open Discussion
  - Opportunities and Challenges

Overview and Background

In accordance with P.A. 23-204, Intermediate Care Facilities Medicaid providers will receive:

- $5.6 million for one-time stabilization funds to support general operations and employees
- Requires DSS to rebase the Medicaid rate over several years
- Allows rate increases, within available appropriations for certain costs
- Prohibits rate increases based on any inflation factors

The following presentation will outline the stabilization funds, rebasing methodology and timeline, Medicaid reimbursement principles, state plan amendment process to ensure federal match, example of a rate calculation and long-term strategic planning.

$5.6 million one-time stabilization funds

- State Plan Amendment (SPA) – SPA 23-0013 was submitted to the Centers for Medicare and Medicaid Services (CMS) on June 29, 2023 and is pending approval.
- Funding was distributed to providers on June 27, 2023.
- Funding was allocated based on the proportional Medicaid payments paid to each facility out of total Medicaid payments to eligible privately-operated ICF/IIDs for dates of service from July 1, 2022 through December 31, 2022.
- Funds are intended to be one-time supplemental payments to support allowable costs under Medicaid.
- Only facilities with residents living in the facility as of June 30, 2023 were eligible to receive funding.
- Consistent with standard operating procedures and the Medicaid Provider Agreement, the Department may conduct reviews and audit of any and all information related to Medicaid payments necessary to assure the appropriateness of Department payments made to Providers, and to ensure the proper administration of the Connecticut Medical Assistance Program, and to assure Provider's compliance with all applicable statutes and regulations and policies. These funds will not be targeted for special audits.

Medicaid Reimbursement Principles

- Medicaid rates are established in accordance with the Medicaid State Plan, §17-311-1 and §17b-340.
- ICF/IIDs receive cost-based Medicaid rates which reflect actual and incurred costs as reported annually to the Department.
- Under federal Medicaid reimbursement principles, Medicaid reimbursement must be established in accordance with Section 1902(a)(30)(A) of the Social Security Act which requires states to ensure that Medicaid "payments are consistent with efficiency, economy, and quality of care".
- In accordance with 42 CFR Part 413 -- Principles of Reasonable Cost. Medicaid programs are required to ensure all payments to Medicaid providers "must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries."
- Costs not related to services provided or costs not within reason are disallowed from Medicaid programs by CMS and states will not receive federal match.
- CMS uses several tests to ensure the reasonableness standard including the state plan amendment, Upper Payment Limits (UPL), and audit of state Medicaid programs. Per federal regulations, UPLs look at a class of providers in the aggregate and not as individual facilities.

Rebasing Predictability and Timeline

- Several years of rebasing have been approved to provide predictability and support long-term strategic planning.
  - **FYE 2024**, rates will be based on:
    1) 2022 cost report submissions
    2) Addition of the 7/1/2022 4.5% increase
    3) Include a 2% adjustment factor
    4) Include a hold harmless for the rate in effect for FYE 2023
    5) No inflationary adjustment factor
    6) Provide pro rata fair rent increases to facilities that have documented fair rent additions
    7) Rate increases for health and safety capital improvement projects approved by DDS and DSS and within available appropriations
    8) Minimum per diem rate remains at $501
    9) All adjustments are applied before hold harmless to FY 23 rate

  - **FYE 2025**, rates will be based on:
    1) 2023 cost report submissions
    2) A facility may receive a rate that is less than the rate in effect for the fiscal year ending June 30, 2024, but shall not receive a rate less than the minimum per diem, per bed rate of $501
    3) No inflationary adjustment factor
    4) Rate increases for health and safety capital improvement projects approved by DDS and DSS and within available appropriations

  - **FYE 2026**, rates will be based on:
    1) 2024 cost report submissions
    2) No minimum per diem
    3) No inflationary adjustment factor

FYE 24 Rate Calculation Example

Please note: Providers will receive a rate computation report with their rate letter. Rate letter will be issued to providers this week.

State Rate

Total Expense	$1,238,947		Page 9
Total Allowable Expense	$1,174,210	A	Page 9 Less B
Total Allowable Expense Per Actual & Imputed Days	$588.5764	C	= A / Days
7/1/2022 Legislative Rate Increase 4.5%	$24.32		
Subtotal	$612.90		
Legislative 2% Adjustment Factor	$12.26		
Computed Rate After Legislative Adjustments	$625.16	**D**	
State Rate for the Period Ending 6/30/2023	$564.74	**E**	
ICF-IID Minimum Rate	$501.00	**F**	
State Rate for the Period Ending 7/1/2023 - 6/30/2024	$625.16	**G**	Greater of D, E, or F

Open Discussion

Opportunities & Challenges