REGULATIONS GOVERNING

THE OPERATION OF

INTERMEDIATE CARE FACILITIES FOR THE

MENTALLY RETARDED

Agency of Human Services
Department of Mental Health
Division of Community Mental Retardation Programs

7.1 Allowable Costs - Allowable costs are defined as those necessary and ordinary costs related to resident care. They must be costs that prudent and cost-conscious management would pay for a given item or service. It should be noted, however, that allowable costs will not be considered for inclusion in reimbursement rate determination unless they have undergone prior budgetary review and have been approved by the Administrative Agency. The following, although not intended as an all-inclusive listing, are presented as specifics to clarify some anticipated areas of misunderstanding.

7.1.1 Depreciation - Depreciation will be an allowable cost when the following guidelines are followed:

a. Method: straight line.

b. Minimum asset life for new facilities and equipment:
   1. Buildings -25 years.
   2. Building improvement - remaining life of building but not less than 15 years.
   3. Equipment - 5 years.
   4. Vehicles - 3 years.
   5. Land improvement - 25 years.
   6. Leasehold improvements - the useful life of the improvement or the remaining term of the lease, whichever is shorter.

c. Asset life for used facilities and equipment: reasonable life expectancy.

d. Basis when purchased new: actual cost (which includes legal fees, shipping charges, etc.).

e. Basis when purchased used: actual cost.

f. Basis limitations: all assets with a life expectancy in excess of one year and an individual cost in excess of $500 must be capitalized and depreciated.

7.1.2 Gains and Losses on Disposition of Equipment - Gains and losses on the sale or abandonment of equipment are includable in computing allowable costs. A gain shall be an offset to depreciation expense to the extent that such gain resulted from depreciation reimbursed under these regulations. Gains or losses on trade-ins should be reflected in the basis of the acquired asset.

7.1.3 Costs of Residency - The costs of residence in the facility for administrators and key staff are allowable costs if such costs together with other compensation, are reasonable.

7.1.4 Cost of Purchases from Related Organizations - The cost of purchases from related organizations are allowable to the extent that they do not exceed the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere, whichever is lower.

7.1.5 Employee Training and Education Costs - Employee training and education costs pertaining to providing or improving patient care are allowable.

7.1.6 One Time, Pre-opening Costs of New Facilities - One time, pre-opening costs of new facilities incurred more than seven days prior to admittance of residents are allowable, but must be capitalized and amortized over a period of no less than 35 consecutive months beginning with the month in which the first resident is admitted for care. Examples of these costs are wages paid for services rendered prior to the opening of the facility. Costs related directly to the purchase, construction, or renovation of the building must be depreciated over the life of the building.

7.1.7 Facility Rental Costs - Facility rental costs under sale and lease-back agreements, lease with option to buy arrangements, or agreements with related organizations will be allowable for the lesser of the actual cost or the cost that would have been allowed if the provider owned the facility.

7.1.8 Indirect Costs - Indirect costs which are distributed from other facility cost centers, or, in the case of state owned facilities, from other state agencies and other cost centers of the facility itself, are allowable costs when the basis for such distribution have a statistical basis and have been approved as part of the budgetary process.

7.1.9 Return on Capital Investment - A reasonable rate of return on capital investment will be considered as an allowable cost for proprietary providers. In addition to the budgetary constraints, return on capital will be further limited to a maximum rate per annum as determined by the Administering Agency and applied to that portion of the owner's equity which is used to serve medical assistance residents.

7.2 Non-allowable Costs - Non-allowable costs may be identified in three areas: cost for services not chargeable to the medical assistance program, cost for expenses not related to patient care or costs not actually incurred, and costs that are judged unreasonable by the Administering Agency.

7.2.1 Services Not Chargeable to ICF/MR Medical Assistance Program - Services not chargeable to the ICF/MR Medical Assistance Program include, but are not limited to, the following list (if in establishing a new service, the facility is unable to find the requirement for such service, the Administering Agency should be contacted for an opinion):

a. Education services.

b. Vocational services.

c. Medical services billable under other provisions of the Medical Assistance Program.

d. Services that are specifically funded directly through other sources at least to the extent to which they are funded.

7.2.2 Cost for Expenses not Related to Patient Care - Cost for expenses not related to patient care or costs not actually Incurred include, but are not limited to, the following:

a. Depreciation for noted assets.

b. Amortization on intangible assets.

c. Bad debts arising from uncollectable resident accounts.

d. Fund raising.

e. Charitable contributions.

f. Entertainment.

7.2.3 Disallowance - The Administering Agency shall have the right to disallow any costs that relate to management inefficiency and/or unnecessary care of facilities. The cost effect of transactions that are conceived for the purpose of circumventing the regulations contained in this publication will be disallowed under the principle that the substance of the transaction shall prevail over form.

7.3 Rate Limitations - Notwithstanding any other provisions of these regulations, the actual cost rate for residential services will not exceed the provider's normal rate charged private residents of comparable residential services.

7.4 Acceptance of Medical Assistance Rate - The provider must accept the actual cost rates as full and final payment for ICF/MR services delivered to the Medical Assistance client.

7.5 Rate Determination

7.5.1 Budgetary Process

a. Each provider will submit, at least two days prior to the first day of its fiscal year, a budget for the ensuing fiscal year, in the format prescribed by the Administering Agency. This budget will contain line items of expense based on prior year's expenses and allowances for known cost changes as described in Paragraph e. of this section. Each line item must be justified by a concise narrative. For personnel costs, position titles and job descriptions must be used. All projected costs included in the budget which do not meet the criteria of allowable costs as defined in the Allowable Costs section of these regulations, must be deducted in the calculation of net cost.

b. This budget will be reviewed by the Administering Agency, adjusted if necessary, and when approved, will serve as a basis for the service payment rate and the calculation of the actual cost rate. Providers will be required to adhere to their approved budget. Expenditures which are in excess of allowable budgetary limits will be reimbursable. Allowable budgetary limits are defined as the approved line item amount plus 10% or $500.00, whichever is greater. Under no circumstances, however, will the total of allowable costs exceed the approved total net cost. If a provider foresees costs exceeding allowable budgetary limits, he may apply to the Administering Agency for a budget amendment. Such request must state justification for the change. Costs, in excess of the allowable budgetary limits, incurred prior to approval by the Administering Agency will not be reimbursable.

c. The service payment rate will be determined by dividing the net cost by the estimated patient days. The provider must indicate the number of certified beds and must estimate patient days based on past experience and known changes, but in no case may estimated patient days indicate an occupancy of less than 85%.

7.5.2 Exceptions to the Budgetary Process

a. State Agencies - State agencies which operate ICF/MR facilities and submit biennial budgets for legislative approval shall be exempt from the budgetary process. For these providers, the service payment rate will be calculated in accordance with the budget as approved by the Legislature. The actual cost rate will be determined in accordance with Paragraph c. of the above section of these regulations, except that budgetary constraints will not be imposed.

b. New Facilities - New facilities will be subject to Paragraph c., above, with the exception that budgets will be derived only from projections of operations for the ensuing fiscal year. New facilities will have the option of having the service payment rate adjusted quarterly if they can substantiate that the service payment race is not within 10% of the actual cost rate. New facilities are defined as those which have not completed one full fiscal year of operation.

c. Loss or Abandonment - Loss on the sale or abandonment of fixed assets may be submitted for consideration after incurrence, but such submission must be within ten days of determination of loss.

7.5.3 Allowance for Known Cost Changes - Future cost increases or decreases, known as of the budget filing date, must be taken into consideration in the budget preparation process. Cost increases will be considered only when they meet the criteria for allowability as defined in the Allowable Costs section of these regulations, and the following requirements:

a. Salary and wage changes must be based on changes in effect at the end of the current period and/or future changes substantiated by labor contracts, board resolutions, written policies, or minimum wage laws.

b. Changes in facility costs will be based on changes in effect at the end of the current period and/or future changes substantiated in the budget narrative.

c. The cost effects based on the need to change program services must be accompanied by justification of, and need for, such change.

d. Cost changes may be justified by references to pertinent Federal, State, or local laws and regulations.

e. Cost changes in all line items not specifically outlined above must be justified by referring to cost changes during the last completed fiscal quarter prior to the budget submission date plus consideration of reasonable increases expected to occur during the budget period.

7.5.4 Written Notification - The Administering Agency will provide written notification of the proposed service payment rate or the actual cost rate within ten days of its determination of such rate. Notification will include the method used in determining such rates and the method of submitting comments from the public to the Administering Agency. The posted, or an adjusted rate, shall become final on the tenth day following the date posted in the notification for receipt of comment.

7.6 Payment Mechanisms - Payments are made to providers from the Department of Mental Health. Providers must submit a properly completed form to:

Department of Social Welfare
Medical Services Division
Waterbury Office Complex
Waterbury, VT 05676

A copy of this form and instructions for completion are attached. Providers should expect payment for verified services within four weeks of mailing completed forms. Providers will receive a form listing any adjustments made to the billings. Information regarding the processing of any claims may be obtained from the Department of Mental Health at 241-2600. The provider will be reimbursed on a monthly basis during its fiscal year at the service payment rate, but no payment will be initiated prior to receipt of required reports. Reimbursement adjustments based on the actual cost rate will be determined within thirty days of receipt of an acceptable audit. If the determination requires a payment to the provider, payment shall be initiated within thirty days after the date of final determination. If the determination requires a repayment from the provider, the provider must make such repayment within ninety days of the final determination.

7.7 Service Payment Rate - The service payment rate will be based upon the total net costs of the approved budget, divided by the estimated resident days. The Administering Agency reserves the right to revise this rate at any time if the rate seems substantially inconsistent with the actual allowable costs.

7.8 Actual Cost Rate - The actual cost rate will be calculated by dividing the allowable costs for the fiscal year, in accordance with the budgetary provisions of the Rate Determination section of these regulations, actual resident days, except if actual resident days are 85% or less of maximum occupancy, 85% occupancy will be used to calculate the actual cost rate. Furthermore, the Administering Agency will require an annual audit (by a qualified person or firm, not connected with the provider), to determine the fairness of the actual cost rate. The Administering Agency may, at its option, provide said audit.

7.9 Record Keeping

7.9.1 All providers receiving Medical Assistance payments for ICF/MR's must meet the following financial accountability requirements:

a. All records must be maintained on a full accrual basis, excepting State agencies shall use a modified cash system approved by the Commissioner of Finance.

b. All non-allowable costs under the services provision in the Non-allowable Costs section of these regulations must be physically segregated (i.e., a separate set of financial records) from allowable costs, or if intermixed with allowable costs, must be readily identifiable for audit purposes. Costs eligible under the provisions of Part H of the Allowable Costs section of these regulations, that readily identify the basis for distribution, meet this condition.

c. All financial records must be maintained in accordance with generally accepted accounting principles and must provide a clear audit trail.

d. All reports required in the Reports section of these regulations will be subjected to a desk audit and may be subjected to a field examination of supporting records and compliance with regulations. If such audits reveal inadequacies in provider record keeping and accounting practices, the Administering Agency may require that the provider engage competent professional assistance to properly prepare the required reports.

e. Clinical records must be maintained in the manner prescribed in the ICF/MR Operating Regulations, and must provide a means of readily identifying the number of resident days. All records and reports pertaining to financial transactions must be maintained by the provider for not less than three years from the date of the submission of an approved audit for the period to which the material pertains.

7.10 Reports

7.10.1 Required Reports - In order to receive reimbursement at the service payment rate, the provider must submit a monthly report, in the format prescribed by the Administering Agency. The report must include cumulative revenue and expenditures according to budgetary line items, an invoice for the units of service rendered, and/or any other data relevant to justification or support of the Medical Assistance rate as deemed necessary by the Administering Agency.

7.10.2 Report Deadlines - All provider reports shall be submitted no later than the 30th of the month following the month being reported. Reports received after this date, and reports received in unacceptable condition, will be subject to at least a thirty day payment delay.

7.10.3 Report Certification - Reports must be certified, in the place indicated, by signature of the operating executive.

7.10.4 False Reports - False information knowingly supplied by the provider on a required report will result in termination of the provider's contractual agreement and/or prosecution under the applicable Federal and State statutes.

7.10.5 Amended Reports - Providers must file amended reports immediately upon discovery of any errors in the number of units of service billed. If an error is discovered in the financial reporting, appropriate adjustments must be made the succeeding month.

7.10.6 Audits - An audit will be conducted annually in accordance with provisions of the Actual Cost Rate section of these regulations. Reports will be submitted to the Administering Agency not more than five months after completion of the fiscal year.

7.11 Absence from Facility - Notwithstanding any other provision of these regulations, nothing herein shall be interpreted as an impediment to having ICF/MR residents: a) visit with family, friends, or other significant persons; or, b) be away from the facility for social, recreational, or related purposes, provided that all visitations and/or absences for which Title XIX reimbursement is sought are consistent with, and part of, the resident's current habilitation plan.

There shall be no limit to the number of such visitation/absent days per year. However, in the event that a resident's habilitation plan provides for visitations/absences in excess of fifteen (15) days per quarter or sixty (60) days per annum, approval for such excess days shall be obtained in advance from the Commissioner of Mental Health.

The Department shall not withhold such approval unless:

a. The resident's habilitation plan does not specifically provide for the amount of visitation/absence requested.

b. The extent of visitation/absence suggests that continued ICF/MR placement is inappropriate.

c. The resident's habilitation plan is not current or has not been reviewed in accordance with facility policy.

7.12 Appeal Procedures

7.12.1 Scope of Appeal Procedure - These procedures describe the manner by which unresolved individual provider disputes concerning application of these regulations shall be settled. Unresolved disputes are defined as those disagreements that cannot be resolved between the provider and the Administering Agency. Such disputes may be appealed by the provider.

7.12.2 Appeal Procedure - An appeal shall be submitted in writing to the Vermont Human Services Board and shall include facts, arguments, and other pertinent data. Appeals shall be heard by the Appeals Examiner who shall be an impartial party designated by the Board.

7.12.3 Time Limit - The provider has thirty days from the date of the Administering Agency's final determination of the matter disputed to initiate formal appeal.

7.12.4 Settlement Mechanism - If the appeal is related to a change in the provider's rate, the amount in dispute will not be adjusted until final determination according to the appeal procedure is made. If the appeal determination requires a payment to the provider, payment shall be initiated within thirty days after the date of final determination. If the appeal determination requires repayment from the provider, the provider must make such repayment within ninety days of the final determination.

7.12.5 Findings and Conclusions - Any findings, conclusions, or opinions of the Appeals Examiner about any appeal will be made available to the provider and to the Administering Agency.