DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 19-N: Publicly Operated Nursing Facility Reimbursement

The State of Connecticut Department of Social Services (DSS) proposes to submit the following Medicaid State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS).

Changes to Medicaid State Plan

Effective on or after September 1, 2019, SPA 19-N will amend Attachment 4.19-D of the Medicaid State Plan to add a reimbursement methodology for a publicly operated Chronic and Convalescent Nursing Home (CCNH) operated by the State of Connecticut Department of Veterans Affairs. This reimbursement methodology will be cost-based and will be based on cost reports and cost reimbursement methodology described in the state plan pages.

Fiscal Impact

Based currently available data, DSS estimates that this SPA will increase annual aggregate Medicaid expenditures by approximately $22.3 million each in State Fiscal Year (SFY) 2020 and SFY 2021.

Obtaining SPA Language and Submitting Comments

This SPA is posted on the DSS website at the following link: http://portal.ct.gov/dss. Scroll down to the bottom of the webpage and click on “Publications” and then click on “Updates”. Then click on “Medicaid State Plan Amendments”. The proposed SPA may also be obtained at any DSS field office, at the Town of Vernon Social Services Department, or upon request from DSS (see below).

To request a copy of the SPA from DSS or to send comments about the SPA, please email: christoper.lavigne@ct.gov or write to: Christopher LaVigne, Office of Certificate of Need and Rate Setting, Department of Social Services, 55 Farmington Avenue, Hartford, CT 06105-3730 (Phone: 860-424-5719, Fax: 860-424-4812). Please reference “SPA 19-N: Publicly Operated Nursing Facility Reimbursement”.

Anyone may send DSS written comments about this SPA. Written comments must be received by DSS at the above contact information no later than August 30, 2019.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Connecticut
Methods for Establishing Payment Rates for Public Skilled Nursing Facility Services

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1) Public Skilled Nursing Facilities:

a. Definition of Public Skilled Nursing Facility Services

The State of Connecticut Department of Veteran's Affairs (CT DVA) provides skilled nursing facility services, both routine and ancillary services for qualified veterans. A CT DVA public skilled nursing facility service billing will be triggered when a Medicaid-eligible client had a recorded inpatient day in a public skilled nursing facility. A Medicaid public skilled nursing facility service "Unit" is defined when a client is present at midnight for the census count. Costs of the facilities are determined in accordance with the Medicare cost identification principles described in PRM-15-2 and OMB Circular A-87. Documentation of a recorded inpatient day shall be maintained in facility's records. A payment for public skilled nursing facility services will not duplicate payments made under Medicaid for other services covered under the program.

b. Interim Rates

Interim rates for public skilled nursing facility services provided by CT DVA shall be updated annually. Interim rates for public skilled nursing facility services will be computed using settled costs from the prior state fiscal year for public skilled nursing facility services provided to Medicaid clients in a public skilled nursing facility services. An inflation factor based on the most recent Medical CPI will be added to the interim rate and rounded up to the nearest $5. The prescribed methodology for the calculation of the interim rates is described below in section "d. Cost Reimbursement Methodology" and the timing of settlement is described below in section "e. Settlement." Interim rates are provisional in nature, pending the completion of cost reconciliation and cost settlement for the rate period, as noted below in section "e. Settlement." Payments for public skilled nursing facility services provided by CT DVA will not duplicate payments made under Medicaid for other covered services.

c. Cost Reports

Final reimbursement is based on the Public Skilled Nursing Facility Services Per Capita Rate Calculation which is a CT DVA certified cost report that is completed by the Connecticut Office of the State Comptroller. Cost reports will include detailed cost data, including direct costs, operating expenses related to direct services, indirect costs, and general and administrative costs in support of public chronic disease hospital services. The Public Skilled Nursing Facility Services Per Capita Rate Calculation prepared by the Office of the State Comptroller shall utilize Form CMS-2452-10 and adhere to the Medicare cost reporting guidelines. The Public Skilled Nursing Facility Services Per Capita Rate Calculation is due to the Department of Social Services no later than 8 months following the close of the state fiscal year during which costs were incurred. Cost reports are subject to desk review by the Department of Social Services or its designee. Desk review will be completed within 8 months following the receipt of the cost reports.

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d. Cost Reimbursement Methodology

In determining Medicaid allowable costs for providing services at a public skilled nursing facility services, the following elements are included and calculations made:

i. Direct costs of providing public skilled nursing facility services shall include salary, wage, fringe benefits and worker's compensation that can be directly charged to public skilled nursing facility services, including costs that are integral to the delivery of public skilled nursing facility services. For purposes of this subsection, allowable direct costs are computed from the following CMS 2540-10 Medicare Cost Report cost centers:

ii. Other direct costs are determined using PRM 15-2 guidelines as used to identify allowable costs included in Form CMS 2452-10. These costs are directly attributable to activities performed by personnel who deliver public skilled nursing facility services and costs necessary to support the delivery of public skilled nursing facility services.

iii. Total direct costs include the sum of items i. and ii. above. Total direct costs are reduced by any federal payments for those costs, resulting in adjusted direct costs for public skilled nursing facility services.

Medicare Cost Center	CMS-2540-10 Cost Center Description	Medicare Cost Report Reference
	Inpatient Routine Cost Centers	
30	Skilled Nursing Facility	Worksheet B, Part I, Line 30, Column 18
	Ancillary Service Centers	
40	Radiology	Worksheet B, Part I, Line 40, Column 18
41	Laboratory	Worksheet B, Part I, Line 41, Column 18
42	Intravenous Therapy	Worksheet B, Part I, Line 42, Column 18
43	Oxygen (Inhalation) Therapy	Worksheet B, Part I, Line 43, Column 18
44	Physical Therapy	Worksheet B, Part I, Line 44, Column 18
45	Occupational Therapy	Worksheet B, Part I, Line 45, Column 18
46	Speech Therapy	Worksheet B, Part I, Line 46, Column 18
47	Electrocardiology	Worksheet B, Part I, Line 47, Column 18
50	Dental Care - Title XIX Only	Worksheet B, Part I, Line 50, Column 18

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iv. Indirect costs shall be allocated using PRM 15-2 guidelines and in accordance with Form CMS 2540-10 and cost report instructions, including a portion of central office costs, a Statewide Cost Allocation Plan (SWCAP) allocation, building and equipment depreciation, and bond interest.

v. Medicaid reimbursable public skilled nursing facility services costs are the sum of item iii. and item iv. above.

vi. The per diem rate for public skilled nursing facility services is calculated by dividing the Medicaid reimbursable public skilled nursing facility services costs under item v. by the total paid days for the same period.

e. Settlement

Public skilled nursing facility service claims paid at the interim rate for public skilled nursing facility services delivered by CT DVA during the reporting period, as documented in the MMIS, will be compared to the total Medicaid reimbursable cost based on the Cost Reimbursement Methodology identified in subsection (d) above. CT DVA's interim rate claims for public skilled nursing facility services will be adjusted in aggregate. This process results in cost reconciliation.

Reconciliation will occur within 24 months of the end of the reporting period contained in the submitted cost report. Connecticut will not modify the CMS-approved scope of costs or the annual cost report methodology without CMS approval. If it has been determined that an overpayment has been made, the Department of Social Services will return the federal share of the overpayment pursuant to 42 CFR 433, Subpart F. If the actual, certified Medicaid reimbursable costs of a public skilled nursing facility services exceed the interim Medicaid rates, the Department of Social Services will submit claims to CMS for the underpayment. Cost settlement will occur within the timelines set forth in 42 CFR 433, Subpart F.

f. Audit

All supporting accounting records, statistical data and all other records related to the provision of public skilled nursing facility services delivered by CT DVA may be subject to audit. If an audit discloses discrepancies in the accuracy and/or allowances of actual direct or indirect costs or statistical data as submitted for each fiscal year by CT DVA, the Department of Social Services' payment rate for such period shall be adjusted as necessary.