DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 20-J: 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 February 1, 2020, SPA 20-J 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 $6.4 million in State Fiscal Year (SFY) 2020 and $18.3 million in 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: Public.Comment.DSS@ct.gov or write to: Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105 (Phone: 860-424-5067). Please reference "SPA 20-J: 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 January 30, 2020.

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 2 CFR Part 200. 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. The prescribed methodology for the calculation of the Per Diem rates is described below in section "d. Cost Reimbursement Methodology" and the timing of settlement to documented costs 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 audited CMS Form 2540-10 Skilled Nursing Facility Cost Report (Cost Report) 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 skilled nursing facility services. The cost report 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 based on the final audited CMS-2540-10 cost report:

Medicare Cost Center	CMS-2540-10 Cost Center Description	Medicare Cost Report Reference
	Inpatient Routine Service Cost Centers	
30	Skilled Nursing Facility	Worksheet B, Part I, Line 30, Column 18

The per diem rate for public skilled nursing facility services is calculated by dividing the Cost reported on Line 30, Column 18 on Worksheet B Part I of the audited Form 2540-10 described above 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 for the applicable state fiscal year. 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 as an adjustment to prior year costs. To the extent applicable, cost settlement will occur within the timelines set forth in 42 CFR 433, Subpart F.

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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.