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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Division of Medicaid and Children's Health Operations / Boston Regional Office

August 29, 2016

Roderick Bremby, Commissioner
Department of Social Services
55 Farmington Avenue
Hartford, CT 06105

Dear Commissioner:

We are pleased to enclose a copy of approved Connecticut State Plan Amendment (SPA) No. 11-017, submitted to my office on September 30, 2011 and approved on August 24, 2016. This SPA amends Attachment 4.19-B of the State Plan in order to establish rates for outpatient services provided by public psychiatric hospitals and amends reimbursement methodology for public mental health clinics. There is no federal budget impact expected. This SPA also updates coverage language for hospitals and behavioral health clinics (also known as mental health clinics).

This SPA has been approved effective July 1, 2011, as requested by the State.

Changes are reflected in the following sections of your approved State Plan:

- Addendum Page 1c & 7 to Attachment 3.1-A
- Addendum Page1c & 7 to Attachment 3.1-B
- Addendum Pages 1 and 1a thru 1j to Attachment 4.19-B page
- Attachment 4.19-B, Page 1(c)
- Attachment 4.19-B, Page 1(c)i through 1(c)vii

If you have any questions regarding this matter you may contact Marie DiMartino (617) 565-9157 or by e-mail at Marie.DiMartino@cms.hhs.gov

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

cc: Kate McEvoy, Director of Medical Administration - Health Services and Supports

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS OF MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 11-017
2. STATE: CT
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
07/01/2011

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
Section 1905(a)(9) of the Social Security Act
Section 1905(a)(2)(A) of the Social Security Act

7. FEDERAL BUDGET IMPACT
a. FFY 2011 $0.00
b. FFY 2012 $0.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Addendum Page 1c & 7 to Attachment 3.1-A
Addendum Page1c & 7 to Attachment 3.1-B
Addendum Pages 1 and 1a thru 1j to Attachment 4.19-B page
Attachment 4.19-B, Page 1(c)
Attachment 4.19-B, Page 1(c)i through 1(c)vii

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION

Addendum Page 1c & 7 to Attachment 3.1-A
Addendum Page1c & 7 to Attachment 3.1-B
NEW
Attachment 4.19-B, Page 1(c)
NEW

10. SUBJECT OF AMENDMENT

Connecticut State Plan Amendment 11-017 proposes to amend Attachment 4.19-B of the Connecticut State Pla in order to establish rates for outpatient services provided by public psychiatric hospitals and amends reimbursement methodology for public menta health clinics. No federal budget impact is expected. This SPA also updates coverage language for hospitals and behavioral health clinics also known as mental health clinics.

11. GOVERNOR'S REVIEW *(Check One)*

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL
/S/

13. TYPED NAME
Roderick L. Bremby

14. TITLE
Commissioner

15. DATE SUBMITTED
September 30, 2011

16. RETURN TO
State of Connecticut
Department of Social Services
25 Sigourney Street
Hartford, CT 06106-5033
Attention: Ginny Mahoney

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
September 30, 2011

18. DATE APPROVED
August 24, 2016

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2011

20. SIGNATURE OF REGIONAL OFFICIAL
/S/

21. TYPED NAME
Richard R. McGreal

22. TITLE
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

23. REMARKS
Pen and ink changes to box 6, 8,9 and 10 approved by Connecticut

FORMS CMS-179 (07/92)

Instructions of Back

State: CONNECTICUT
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

2. a. Outpatient Hospital Services. Outpatient hospital services are provided in accordance with 42 CFR 440.20.

Covered services in outpatient psychiatric hospitals include, but are not limited to, (i) routine outpatient, (ii) intensive outpatient, (iii) day treatment, (iv) partial hospitalization, and (v) other services authorized in accordance with state law within the scope of the hospital's license, or, for hospitals operated by the Department of Mental Health and Addiction Services, other services authorized in accordance with state law.

No more than one (1) visit per day to the same outpatient hospital clinic, except for: (i) outpatient psychiatric clinic services at acute care hospitals, (ii) public or private freestanding psychiatric hospitals, or (iii) publicly operated psychiatric outpatient hospital clinics. When applicable, this limit simply reflects the billing requirement that the hospital may bill the same visit code only once per day for the same beneficiary.

No more than one (1) psychiatric/psychological reevaluation per year per hospital for the same recipient, which may be exceeded by prior authorization based on medical necessity. For hospitals operated by the Department of Mental Health and Addiction Services, no more than one (1) psychiatric / psychological evaluation per performing provider, per episode of care for the same recipient, but no more frequently than one per year, which may be exceeded by prior authorization based on medical necessity.

b. Rural Health Clinic Services. There are no Rural Health Clinics in Connecticut.

c. Federally Qualified Health Center (FQHC)

1. The Department subjects nonemergency dental services provided by federally qualified health centers to prior authorization. Nonemergency services that are exempt from prior authorization include diagnostic, prevention, basic restoration procedures and nonsurgical extractions that are consistent with standard and medically necessary dental practices.

2. Federally qualified health center dental clinics must be licensed under Regulations of Connecticut State Agencies Sections 19-13-D45 to 19-13-D53, inclusive.

3. The Department will only pay for orthodontia for individuals under twenty-one (21) years of age.

4. Services must meet the requirements of 42 CFR 440.100 and are limited to the dental provider's scope of practice.

5. The limitations in Section 10(b) and 10(c) which are found in Addendum Page 8a to Attachment 3.1-A also apply.

3. Other Laboratory and X-Ray Services. No limitation on services.

EXPLANATORY FOOTNOTE: Although the coverage page for approved SPA 12-005 was approved out of order, the approval of that SPA is intended to be preserved until it was substantively modified by another SPA with the same or later effective date. See letter dated July 13, 2016 in the SPA record for SPA 11-017 for details.

State: CONNECTICUT

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
CATEGORICALLY NEEDY GROUP(S): ALL

2. a. Outpatient Hospital Services. Outpatient hospital services are provided in accordance with 42 CFR 440.20.

Covered services in outpatient psychiatric hospitals include, but are not limited to, (i) routine outpatient, (ii) intensive outpatient, (iii) day treatment, (iv) partial hospitalization, and (v) other services authorized in accordance with state law within the scope of the hospital's license, or, for hospitals operated by the Department of Mental Health and Addiction Services, other services authorized in accordance with state law.

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EXPLANATORY FOOTNOTE: Although the coverage page for approved SPA 12-005 was approved out of order, the approval of that SPA is intended to be preserved until it was substantively modified by another SPA with the same or later effective date. See letter dated July 13, 2016 in the SPA record for SPA 11-017 for details.

State Connecticut
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED TO
CATEGORICALLY NEEDY GROUP(S): ALL

d. Medical Clinics licensed by the Department of Public Health under Section 19-13-D45 of the Regulations of Connecticut State Agencies.
Limitation: No more than one (1) visit per day of the same type of service per recipient.

e. Behavioral Health Clinics (also known as Mental Health and Substance Abuse Clinics): (a) licensed by the Department of Public Health as a Psychiatric Outpatient Clinic for Adults, a Mental Health Day Treatment Facility, or a Facility For the Care or Treatment of Substance Abusive or Dependent Persons; (b) licensed by the Department of Children and Families as an Outpatient Psychiatric Clinic for Children; or (c) operated by the Deparment of Mental Health and Addiction Services. Services include, but are not limited to, routine outpatient, intensive outpatient, day treatment, partial hospitalization, and other behavioral health clinic services authorized in accordance with state law within the scope of the clinic's license.
Limitations:
(1) No more than one (1) therapy session of the same type per day per clinic for the same recipient.
(2) No more than one (1) psychiatric diagnostic evaluation per performing provider per episode of care for the same recipient. For clinics operated by the Department of Mental Health and Addiction Services, no more than one (1) psychiatric / psychological evaluation per performing provider, per episode of care for the same recipient, but no more frequently than one per year, which may be exceeded by prior authorization based on medical necessity.
(3) No more than twelve (12) persons per group therapy session provided to individuals in routine outpatient settings. Limitation does not apply to multi-family groups or intermediate care programs.

f. Rehabilitation Clinics accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) on the Joint Commission on Accreditation of Healthcare Organization (JCAHO). A copy of the medical director's current physician license and statement accepting full professional responsibility for the services are also required.
Limitations:
(1) No more than one (1) complete evaluation per year involving the same treatment modality per provider for the same recipient.
(2) No more than one (1) full impedence battery, tympanometry test or electronystagmography per provider clinic for the same recipient per year.
(3) No more than one (1) treatment session per day for the same procedure per provider clinic for the same recipient.

g. Methadone Maintainence Clinics licensed by the Department of Public Health under Section 19a-495-570 of the Regulations of Connecticut State Agencies.

d. Medical Clinics licensed by the Department of Public Health under Section 19-13-D45 of the Regulations of Connecticut State Agencies.
Limitation: No more than one (1) visit per day of the same type of service per recipient.

e. Behavioral Health Clinics (also known as Mental Health and Substance Abuse Clinics): (a) licensed by the Department of Public Health as a Psychiatric Outpatient Clinic for Adults, a Mental Health Day Treatment Facility, or a Facility For the Care or Treatment of Substance Abusive or Dependent Persons; (b) licensed by the Department of Children and Families as an Outpatient Psychiatric Clinic for Children; or (c) operated by the Deparment of Mental Health and Addiction Services. Services include, but are not limited to, routine outpatient, intensive outpatient, day treatment, partial hospitalization, and other behavioral health clinic services authorized in accordance with state law within the scope of the clinic's license.
Limitations:
(1) No more than one (1) therapy session of the same type per day per clinic for the same recipient.
(2) No more than one (1) psychiatric diagnostic evaluation per performing provider per episode of care for the same recipient. For clinics operated by the Department of Mental Health and Addiction Services, no more than one (1) psychiatric / psychological evaluation per performing provider, per episode of care for the same recipient, but no more frequently than one per year, which may be exceeded by prior authorization based on medical necessity.
(3) No more than twelve (12) persons per group therapy session provided to individuals in routine outpatient settings. Limitation does not apply to multi-family groups or intermediate care programs.

f. Rehabilitation Clinics accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) on the Joint Commission on Accreditation of Healthcare Organization (JCAHO). A copy of the medical director's current physician license and statement accepting full professional responsibility for the services are also required.
Limitations:
(1) No more than one (1) complete evaluation per year involving the same treatment modality per provider for the same recipient.
(2) No more than one (1) full impedence battery, tympanometry test or electronystagmography per provider clinic for the same recipient per year.
(3) No more than one (1) treatment session per day for the same procedure per provider clinic for the same recipient.

g. Methadone Maintainence Clinics licensed by the Department of Public Health under Section 19a-495-570 of the Regulations of Connecticut State Agencies.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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(d) Medical Clinics: The current fee schedule was set as of July 1, 2008[1] and is effective for services provided on or after that date. All rates are published at www.ctdssmap.com. Rates are the same for private and governmental providers.

[1] **EXPLANATORY FOOTNOTE 1**: This SPA does not affect the previous out-of-order approval of SPA 15-002, which remains in effect from its effective date until substantively modified by a SPA with the same or later effective date. The effective date and superseded SPA are listed here in order to be consistent with the language and effective date for SPA 11-017. See the letter dated July 13, 2016 in the SPA record for SPA 11-017 for additional details.

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(e) Behavioral Health Clinics:

(e.1) **Private Behavioral Health Clinics.**

The current fee schedule was set as of July 1, 2008[2] and is effective for services on or after that date. Fees for services provided to individuals 18 years of age and over will be 95% of the published fee.

Effective July 1, 2008[3] the Department established a separate fee schedule for private behavioral health clinics other than Federally Qualified Health Centers that meet special access and quality standards and such fees are higher than the fees available to clinics that do not meet such special standards. Fees for services provided to individuals 18 years of age and over will be 95% of the published fee.

All fees are published at www.ctdssmap.com. Rates are the same for private and governmental providers.

[2] See Explanatory Footnote 1.
[3] See Explanatory Footnote 1.

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State of Connecticut

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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(e.2) **Public Behavioral Health Clinics.**

Behavioral health clinic services pursuant to 42 C.F.R. § 440.90 as described in Attachments 3.1-A and Attachment 3.1-B and associated addendum pages are reimbursed by Medicaid when provided by the Department of Mental Health and Addiction Services (DMHAS) in a public behavioral health clinic to a Medicaid beneficiary and at least one outpatient behavioral health clinic service for that day is recorded for the beneficiary in the clinic. Reimbursement for private behavioral health clinics is described above. Documentation of services shall be maintained in the beneficiary's service record. Payment for outpatient services delivered by DMHAS in public behavioral health clinics may not duplicate Medicaid payments for other Medicaid covered services.

1. **Definitions applicable to this section:**
   - **1.1** Facility – a public behavioral health clinic where behavioral health clinic services are delivered as described in Attachment 3.1A and 3.1B. Each facility has its own NPI number.
   - **1.2** Rate Period – is the state fiscal year (SFY) beginning July 1 and ending June 30 of each year.
   - **1.3** Cost Report – CMS-approved Medicaid cost report for Public Outpatient clinic services.
   - **1.4** Reimbursable Cost – shall include salaries and wages, fringe benefits and indirect cost.
   - **1.5** Indirect Cost – indirect cost is calculated using the HHS approved indirect cost rate
   - **1.6** Unit of Service - outpatient behavioral health clinic services pursuant to 42 C.F.R. § 440.90 described in Attachments 3.1-A and 3.1-B and associated addendum pages.

2. **Interim Rates:**

Interim rates for outpatient services provided by DMHAS in public behavioral health clinics shall be updated annually. Interim rates for outpatient services in public behavioral health clinics

will be computed using settled costs from the prior state fiscal year for public outpatient services provided to Medicaid clients in a public behavioral health clinic rounded up to the nearest $10. The cost reimbursement methodology is described below in section "4. Cost Reimbursement Methodology" and the timing of settlement is described below in section "5. Cost 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 "5. Cost Settlement." Payments for public outpatient services provided by DMHAS behavioral health clinics will not duplicate payments made under Medicaid for other covered services.

3. Cost Reports:

Final reimbursement for outpatient services provided by DMHAS in public behavioral health clinics is based on the certified by DMHAS cost report.

DMHAS shall complete and certify a cost report for outpatient services delivered by DMHAS in public behavioral health clinics during the previous State fiscal year. The reimbursable outpatient cost shall be determined in accordance with principles described in Medicare Provider Reimbursement Manual and OMB Circular A-87. Cost reports are due to the Department of Social Services no later than 10 months following the close of the State fiscal year during which the costs included in the cost report were incurred. The cost report shall include certification of funds by DMHAS. Submitted cost reports are subject to desk review by the Department of Social Services or its designee. Desk review shall be completed within 8 months following the receipt of cost reports.

4. Cost Reimbursement Methodology:

In determining Medicaid allowable costs for providing outpatient services delivered in public behavioral health clinics, the following elements shall be included and calculations shall be made:

4.1 Subtotal direct cost net of physician costs shall include salary and wages and fringe benefits. Direct cost shall not include room and board charges.

4.2 Adjusted subtotal direct costs net of physician costs removes any federal reimbursement from the Subtotal direct cost net of physician costs (item 4.1).

4.3 Indirect cost shall be calculated by applying the HHS approved indirect cost rate for the cost reporting period to the adjusted subtotal direct costs net of physician costs (item 4.2).

4.4 Total costs net of physician costs is the sum of the adjusted subtotal direct costs net of physician costs (item 4.2) and the indirect cost applicable to direct cost (item 4.3).
4.5 Outpatient program costs net of physician costs shall be calculated by applying outpatient allocation base, a result of the CMS approved RMTS, to the total direct cost net of physician costs (item 4.4).
4.6 Medicaid penetration rate is the percent of Medicaid outpatient services of the total outpatient services recorded for the cost reporting period in DMHAS' WITS services report or its replacement.
4.7 Medicaid allowable direct cost net of physician costs is the result of applying the Medicaid penetration rate (item 4.6) to the outpatient program cost net of physician costs (item 4.5).
4.8 Medicaid allowable physician costs include salary and wages, fringe benefits, and indirect costs. It shall be calculated by multiplying the physician's reported hours of Medicaid visits and their hourly salary. Outpatient fringe benefits are calculated by taking their outpatient salary over their total annual salary, and applying the percentage to their fringe benefits. Physician indirect cost shall be calculated by applying the HHS approved indirect cost rate for the cost reporting period to sum of outpatient salary and fringe benefits.
4.9 Medicaid allowable certified public expenditure (CPE) is the sum of the total Medicaid allowable direct cost net of physician costs (item 4.7) and the total Medicaid allowable physician cost (item 4.8).

5. Cost Settlement:
DMHAS claims paid at the interim rates for outpatient services delivered in public behavioral health clinics during the reporting period, as documented in the MMIS, will be compared to the total Medicaid allowable cost for outpatient services delivered in public behavioral health clinics based on the CMS approved cost report identified as per item (4). DMHAS interim rate claims for outpatient services delivered in public behavioral health clinics will be adjusted in aggregate. This results in cost reconciliation. Reconciliation will occur within 24 months of the end of the reporting period contained in the submitted cost report. If it has been determined that an overpayment has been made, the Department of Social Services will return the federal share of the overpayment. If the actual, certified Medicaid allowable costs of outpatient services delivered in public behavioral health clinics 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. Connecticut will not modify the CMS-approved scope of costs, time study methodology or the annual cost report methodology without CMS approval.

6. Audit:

All supporting accounting records, statistical data and all other records related to the provision of the outpatient services delivered by DMHAS in public behavioral health clinics is 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 DMHAS, the Department of Social Services' Medicaid payment rate for the said period is subject to adjustment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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(f) Rehabilitation Clinics:

Effective September 1, 2008, reimbursement for physical therapy and occupational therapy provided by rehabilitation clinics will change from a per visit fee to CPT modality-specific fee based reimbursement. The current fee schedule was set as of September 1, 2008[4] and is effective for services provided on or after that date. All rates are published at www.ctdssmap.com.

[4] See explanatory footnote 1.

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[Intentionally left blank to accommodate pagination for future outpatient hospital SPA.]

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Outpatient public hospital psychiatric services

The outpatient services delivered in a public psychiatric hospital described in Addendum Page 1c to Attachment 3.1A and 3.1B will trigger Medicaid billing when delivered by the Department of Mental Health and Addiction Services on the same day in a public psychiatric hospital to Medicaid-eligible client and client has at least one recorded outpatient service on the same day. Documentation of outpatient service as referred to above shall be maintained in client's service record. Payment for outpatient services delivered by the Department of Mental Health and Addiction Services in a public psychiatric hospital may not duplicate payments made under Medicaid for other services covered under the Medicaid program.

1. **Definitions applicable to this section:**
   - **1.1** Facility – a public psychiatric hospital where outpatient hospital services are delivered as described in in Attachments 3.1-A and 3.1-B and associated addendum pages. Each facility has its own NPI number.
   - **1.2** Rate Period – is the state fiscal year (SFY) beginning July 1 and ending June 30 of each year.
   - **1.3** Cost Report –

CMS-approved Medicaid cost report for Public Outpatient clinic services.

   - **1.4** Reimbursable Cost – shall include salaries and wages, fringe benefits and indirect cost.
   - **1.5** Indirect Cost – indirect cost is calculated using the HHS approved indirect cost rate
   - **1.6** Unit of Service - outpatient psychiatric hospital services pursuant to 42 C.F.R. 440.20 described in Attachments 3.1-A and 3.1-B and associated addendum pages.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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2. **Interim Rates:**
Interim rates for outpatient services provided by DMHAS in public psychiatric hospitals shall be updated annually. Interim rates for outpatient services in public psychiatric hospitals will be computed using settled costs from the prior state fiscal year for public outpatient services provided to Medicaid clients in a public psychiatric hospitals rounded up to the nearest $10. The cost reimbursement methodology is described below in section "4. Cost Reimbursement Methodology; and the timing of settlement is described below in section "5. Cost Settlement." Interim rates are provisional in nature, pending the completion of cost reconciliation and cost settlement for the rate period. Payments for public outpatient services provided by DMHAS psychiatric hospitals will not duplicate payments made under Medicaid for other covered services.

3. Cost Reports:
Final reimbursement for outpatient services provided by DMHAS in public psychiatric hospitals is based on the certified by DMHAS cost report. DMHAS shall complete and certify a cost report for outpatient services delivered by DMHAS in public psychiatric hospitals during the previous State fiscal year. The reimbursable outpatient cost shall be determined in accordance with principles described in Medicare Provider Reimbursement Manual and 2CFR Part 225 (OMB Circular A-87). Cost reports are due to the Department of Social Services no later than 10 months following the close of the State fiscal year during which the costs included in the cost report were incurred. The cost report shall include certification of funds by DMHAS. Submitted cost reports are subject to desk review by the Department of Social Services or its designee. Desk review shall be completed within 8 months following the receipt of cost reports.

4. Cost Reimbursement Methodology:
In determining Medicaid allowable costs for providing outpatient services delivered by DMHAS in public psychiatric hospitals, the following elements shall be included and calculations shall be made:

4.1 Subtotal direct cost net of physician costs shall include salary and wages and fringe benefits. Direct cost shall not include room and board charges.

4.2 Adjusted subtotal direct costs net of physician costs removes any federal reimbursement from the Subtotal direct cost net of physician costs (item 4.1).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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4.3 Indirect cost applicable to direct RMTS cost shall be calculated by applying the HHS approved indirect cost rate for the cost reporting period to the adjusted subtotal direct costs net of physician costs (item 4.2).

4.4 Total costs net of physician costs is the sum of the adjusted subtotal direct costs net of physician costs (item 4.2) and the indirect cost applicable to direct cost (item 4.3).
4.5 Contracted employee allowable costs shall include salaries and wages and fringe benefits for contracted non-physician employees providing direct services at DMHAS' public psychiatric hospitals.

4.6 Outpatient program costs net of physician costs shall be calculated by applying outpatient allocation base, a result of the CMS approved RMTS, to a sum of the total direct cost net of physician costs (item 4.4) and contracted employee costs (item 4.5).

4.7 Medicaid penetration rate is the percent of Medicaid outpatient services of the outpatient services recorded for the cost reporting period in DMHAS' WITS services report or its replacement.

4.8 Medicaid allowable direct cost net of physician costs is the result of applying the Medicaid penetration rate (item 4.7) to the outpatient program cost net of physician costs (item 4.6).

4.9 Medicaid allowable physician costs are a sum of physicians' salary and wages, physicians' fringe benefits, and physicians' indirect cost. Physicians' outpatient salary and wages cost is calculated by multiplying each physician's reported hours of outpatient Medicaid visits by physician's hourly salary. Physicians' outpatient fringe benefits cost is calculated by dividing each physician's outpatient Medicaid salary, as calculated above, by physician's total annual salary and applying the resulting percentage to physician's total annual fringe benefits. Physicians' indirect cost shall be calculated by applying the HHS approved indirect cost rate for the cost reporting period to sum of physician's outpatient salary and outpatient fringe benefits as calculated above.

4.10 Medicaid allowable physician costs for contracted employees include salary and wages and fringe benefits. Outpatient alary and wages cost is calculated by multiplying physician's reported hours of outpatient Medicaid visits by physician's hourly salary. Outpatient fringe benefits cost is calculated by dividing each physician's outpatient Medicaid salary, as calculated above, by

physician's total annual salary and applying the resulting percentage to physician's total annual fringe benefits.

4.11 Medicaid allowable certified public expenditure (CPE) is the sum of the total Medicaid allowed direct cost net of physicians' costs (item 4.8) and the total Medicaid allowable physicians' cost (sum of items 4.9 and 4.10).

5. Cost Settlement:
DMHAS claims paid at the interim rates for outpatient services delivered in public psychiatric hospitals during the reporting period, as documented in the MMIS, will be compared to the total Medicaid allowable cost for outpatient services delivered in in public psychiatric hospitals based on the CMS approved cost report identified in section 3. DMHAS interim rate claims for outpatient services delivered in public psychiatric hospitals will be adjusted in aggregate. This results in cost reconciliation. Reconciliation will occur within 24 months of the end of the reporting period contained in the submitted cost report. If it has been determined that an overpayment has been made, the Department of Social Services will return the federal share of the overpayment. If the actual, certified Medicaid allowable costs of outpatient services delivered in in public psychiatric hospitals 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. Connecticut will not modify the CMS-approved scope of costs, time study methodology or the annual cost report methodology without CMS approval.

6. Audit:
All supporting accounting records, statistical data and all other records related to the provision of the outpatient services delivered by DMHAS in in public psychiatric hospitals is 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 DMHAS, the Department of Social Services' Medicaid payment rate for the said period is subject to adjustment.