

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, M/S S3-13-15
Baltimore, MD 21244-1850



Center for Medicaid, CHIP and Survey & Certification (CMCS)

Mr. Michael P. Starkowski, Commissioner
Department of Social Services
25 Sigourney Street
Hartford, CT 06106-5033

AUG 18 2010

RE: TN 09-021

Dear Mr. Starkowski:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 09-021. This amendment revises the methodology used to calculate payment rates for inpatient hospital services. Specifically, it maintains the reimbursement rates in effect for fiscal year 2009 through fiscal years 2010 and 2011 with no inflation adjustment. In addition, it adds a provision relating to cost report audits pursuant to a recommendation of the Connecticut Auditors of Public Accounts to assure consistency with State regulation.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. We are pleased to inform you that Medicaid State plan amendment 09-021 is approved effective October 1, 2009. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Novena James-Hailey at (617) 565-1291.

Sincerely,



J Cindy Mann
Director
Center for Medicaid and State Operations (CMSO)

Enclosures:

cc: Mark Schaefer, Acting Director, DSS

**TRANSMITTAL AND NOTICE OF APPROVAL
OF STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:
09-021

2. STATE: CT

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

TO: NATIONAL INSTITUTIONAL REIMBURSEMENT TEAM
CMS/CMSO
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
10/01/2009

5. TYPE OF STATE 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:
42 CFR 447.253(a) and (b)

7. FEDERAL BUDGET IMPACT at 61.59%:
a. FFY 2010 - \$2.3 million savings
b. FFY 2011 - \$5.3 million savings

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A Pages 1(i), 1(ii) & 1(iii)

9. PAGE NUMBER OF THE SUPERSEDED PLAN
SECTION OR ATTACHMENT (If applicable)
Attachment 4.19A Pages 1(i), 1(ii) & 1a

10. SUBJECT OF AMENDMENT:

Methods and Standards for Establishing Payment Rates for Inpatient Hospital Services

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:
Comments, if any, to follow.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

[Redacted Signature]

13. TYPED NAME: Michael P. Starkowski

14. TITLE: Commissioner

15. DATE SUBMITTED:
July 27, 2010 (amends 12/22/09 filing)

16. RETURN TO:

State of Connecticut
Department of Social Services
25 Sigourney Street
Hartford, CT 06106-5033
Attention: Gary Richter, CON & Rate Setting

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: 8-18-10

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
OCT - 1 2009

20. SIGNATURE OF REGIONAL OFFICIAL:

[Redacted Signature]

21. TYPED NAME: William Lasowski

22. TITLE: Deputy Director, CMCS

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Connecticut

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care (continued)

3. The State agency shall reimburse out-of-state and border hospitals utilizing the methodology as set forth in subsection (b)1. or (b)2. above unless a different methodology is required by federal law, in which case, the required federal methodology shall be employed.

- (2) The basis for payment for Administratively Necessary Days to Connecticut Hospitals.

For hospital patients who no longer require acute hospital care, the Department will only pay for those patients who qualify for Medicaid certified Skilled Nursing Facility or Intermediate Care Facility services at the rate established pursuant to number 1 above and as specified below in (a) and (b).

- (a) As an interim rate of payment to hospitals, prior to cost settlement, the Department will pay:
 - (1) for the first seven days of hospital care for patients who no longer require acute care, a rate which is equal to fifty percent (50%) of the hospital's interim non-intensive care per diem rate;
 - (2) for the eight through fourteenth day of such care a rate which is equal to seventy-five (75%) of the hospital's interim non-intensive care per diem rate;
 - (3) for days of such care after the fourteenth day a rate equal to one hundred percent (100%) of the hospital's interim non-intensive care per diem rate.
- (b) As a rate of payment to hospitals for cost settlement purposes, the Department will pay:
 - (1) for the first seven days of hospital care for patients who no longer require acute care, a rate which is equal to fifty percent (50%) of the hospital's non-intensive care per diem rate;
 - (2) for the eight through fourteenth day of such care, a rate which is equal to seventy-five percent (75%) of the hospital's non-intensive care unit per diem rate;
 - (3) for days of such care after the fourteenth day, a rate equal to one hundred percent (100%) of the hospital's non-intensive care unit per diem rate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Connecticut

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care (continued)

(with addition of ten percent incentive, if applicable) increased by 6.5%; or (2) 80% of the cost per discharge per the 2005 cost report filings, but not to exceed \$10,750 per discharge or 142.5% of the 2007 Medicaid Cost Per Discharge (with addition of ten percent incentive, if applicable). Hospitals qualifying for an allowable cost per discharge increase under (1) or (2), shall not receive the ten per cent incentive identified in Section 4005 of Public Law 101-508.

Effective April 1, 2009, general acute care hospital inpatient rates shall be adjusted for admissions that meet the criteria established in section 1(k) of the Addendum to Attachments 3.1-A and 3.1-B, Page 1(b). The methodology is as follows:

1. Hospitals are required to run all Medicaid claims through a Medicare diagnosis-related grouper to determine the Medicare payment amount with and without the present on admission indicator.
2. Hospitals are required to report to the Department all Medicaid claims with a present on admission indicator where Medicare payment was reduced. The report shall include the payment amount with the indicator and the payment amount without the indicator.
3. The Department will calculate the Medicare payment reduction percentage and apply this same percentage reduction to the Medicaid allowed amount per discharge during the annual cost settlement.

All Medicaid cost settlement report filings shall be subject to adjustment as specified in Section 17-312-105(g) of the Regulations of Connecticut State Agencies. The department may also conduct special reviews of a hospital cost report filing to verify significant aberrations from cost year to cost year filings by a hospital or in comparison to other hospitals. Cost or statistical data that is not adequately documented or is unallowable, shall be adjusted and any cost settlements or rates established based on such data shall be revised accordingly.

(b) In reimbursing for inpatient hospital services to out-of-state and border hospitals the State agency will apply the following methodologies:

1. A fixed percentage shall be calculated by the State agency based on the ratio between the allowed cost for all Connecticut in-state hospitals, applying Medicare retrospective reasonable cost reimbursement principles, and total customary charges for all Connecticut instate hospitals, or
2. Each out-of-state and border hospital may have its fixed percentage optionally determined based on its total allowable cost under Medicare principles of reimbursement pursuant to 42 CFR 413. The State agency shall determine from the hospital's most recently available Medicare cost report filed with the State agency the ratio of total allowable inpatient costs to gross inpatient revenue. The resulting ratio shall be the hospital's fixed percentage not to exceed one hundred percent (100%). For any hospital with a fixed percentage that exceeds seventy-five percent (75%), the State agency may review the supporting documentation and make any adjustment required in favor of the hospital or the State as a result of the review.

TN # 09-021
Supersedes
TN #09-003

Approval Date AUG 18 2010

Effective Date 10/1/09

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Connecticut

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

- (1) The basis for payment is the Medicare retrospective reasonable cost reimbursement methodology for prospective payment system-exempt hospitals in effect prior to adoption of the Balanced Budget Act of 1997 (Medicare TEFRA Reimbursement Principles).
 - (a) In reimbursing for inpatient hospital services to Connecticut hospitals provided under the State Plan, the State agency will apply Medicare standards and principles for prospective payment system-exempt hospitals as specified in 42 U.S.C. § 1395ww, as amended through August 15, 1995 by various acts, including, but not limited to, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), § 4005 of the Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, 104 Stat. 1388 (1990) (OBRA '90) and the Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66 ("OBRA '93"); and federal regulations under TEFRA, OBRA '90, and OBRA '93 in effect on August 15, 1995, including, but not limited to, 42 C.F.R. §§413.40(a)C1) et seq. and 413.86, and state regulations in effect as of August 15, 1995 (Sections 17-312-101 through 17-312-105) with: 1) graduate medical education reimbursed as a pass through based on the Medicaid inpatient percentage of full-time equivalent (FTE) residents multiplied by the Medicare allowed per resident amount; 2) provider-based physician (PBP) professional costs allowed as a pass-through and computed by: a) for each ancillary cost center, the difference between a cost to charge ratio that includes PBP professional costs and a cost to charge ratio that excludes PBP professional costs is applied to Medicaid ancillary charges for that cost center, and b) for routine cost centers, the ratio of Medicaid days to total patient days is applied to the PBP professional costs in each routine cost center; and 3) organ acquisition costs reimbursed as a pass through based on the number of Medicaid transplants multiplied by the Medicare allowed amount. Effective October 1, 1998, inpatient services to patients treated in burn units certified by the American Burn Association shall be paid at a rate of \$2,200.00 per day for the first sixteen days of inpatient service, not subject to cost per discharge settlement, and any inpatient days in excess of sixteen days shall be treated as a separate admission subject to cost per discharge settlement. Effective October 1, 2001 there shall be an update to a hospital's target amount per discharge to the actual allowable cost per discharge based upon the 1999 cost report filing multiplied by sixty-two and one-half percent if such amount is higher than the target amount per discharge for the rate period beginning October 1, 2000, as adjusted for the ten per cent incentive identified in Section 4005 of Public Law 101-508. If a hospital's allowable cost per discharge is increased to sixty-two and one-half percent of the 1999 cost per discharge, the hospital shall not receive the ten per cent incentive identified in Section 4005 of Public Law 101-508. Effective August 1, 2003, heart and liver transplants shall be reimbursed utilizing payment rates authorized under the Medicare program. Effective April 1, 2005, the revised target amount per discharge for each hospital with a target amount per discharge less than three thousand seven hundred fifty dollars shall be three thousand seven hundred fifty dollars. Effective October 1, 2006, the revised target amount per discharge for each hospital with a target amount per discharge less than four thousand dollars shall be four thousand dollars. For the rate periods between October 1, 2002 and September 30, 2011, there shall be no application of an annual adjustment factor to the target amount per discharge. Effective October 1, 2007, the revised target amount per discharge shall be the higher of (1) the hospital's 2007 Medicaid Cost Per Discharge Target

OS Notification

State/Title/Plan Number: Connecticut 09-021
Type of Action: SPA Approval
Required Date for State Notification: August 25, 2010
Fiscal Impact: FY 2010 -\$2,300,000 FFP
FY 2011 -\$5,300,000 FFP

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0

Eligibility Simplification: No

Provider Payment Increase: No

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: 0

Reduces Benefits: No

Detail: Effective October 1, 2009, this amendment proposes to maintain the reimbursement rates in effect for fiscal year 2009 through fiscal years 2010 and 2011 with no inflation adjustment. In addition, it adds a provision relating to cost report audits pursuant to a recommendation from the Connecticut Auditors of Public Accounts to assure consistency with State regulation.

Other Considerations: The negative fiscal impact is a result of the rate freeze for both fiscal years. Based on the State's response to concerns about access to care, the RO is not aware of any access issues. Responses to the funding questions were satisfactory. CMS is satisfied that the State has met all the Federal requirements. We do not recommend the Secretary contact the governor. This OSN has been reviewed in the context of the ARRA and approval of the OSN is not in violation of ARRA provisions.

CMS Contact: Novena James-Hailey, (617) 565-1291