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State/Territory Name: CT

State Plan Amendment (SPA) #: 12-002

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICE
Centers for Medicare & Medicaid Services
7500 Security Boulevard, M/S S3-14-28
Baltimore, MD 21244-1850

Center for Medicaid and CHIP Services (CMCS)

Roderick L. Bremby, Commissioner
Department of Social Services
25 Sigourney Street
Hartford, CT 06106-5033

OCT 23 2012

RE: TN 12-002

Dear Mr. Bremby:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 12-002. This amendment revises the reimbursement methodologies for various inpatient settings to support the transition from a 1915(b) managed care waiver delivery method to an Administrative Service Only (ASO) fee-for-service delivery model.

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 12-002 is approved effective January 1, 2012. 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,

Cindy Mann
Director, CMCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

REVISED - September 24, 2012

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 12-002
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
1/01/12

5. TYPE OF STATE PLAN MATERIAL (Check One):

__ NEW STATE PLAN __AMENDMENT TO BE CONSIDERED AS NEW PLAN _X_ AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1905(a)(1) of the Social Security Act
42 CFR 447.253(a) and (b)

7. FEDERAL BUDGET IMPACT:
a. FFY 2012: $ 76.6 M costs
b. FFY 2013: $ 98.1 M costs

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A Pages 1(ii) – 1 (iv)
Attachment 4.19A Pages 1(v) – 1 (vii) (New)
Attachment 4.19A Page 32

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If applicable)
Attachment 4.19A Pages 1(ii) – 1(iv)
(New)
Attachment 4.19A Page 32

10. SUBJECT OF AMENDMENT:

Methods and Standards for Establishing Payment Rates for General and Psychiatric Inpatient Hospital Services

11. GOVERNOR'S REVIEW (Check One):

_X_ 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:

13. TYPED NAME: Roderick L. Bremby

14. TITLE: Commissioner

15. DATE SUBMITTED:
March 30, 2012

16. RETURN TO:

Department of Social Services
25 Sigourney Street
Hartford, CT 06106-5033
Attn: Kate McEvoy, Acting Director, Division of Health Services

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: OCT 23 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JAN - 1 2012

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, CMCS

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of 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.

Effective January 1, 2012, inpatient hospital target amounts per discharge shall be:

	Target
BACKUS	$4,201.23
BRIDGEPORT	$8,078.00
BRISTOL	$3,590.39
DANBURY	$5,377.29
DAY KIMBALL	$3,866.90
DEMPSEY	$11,030.55
GREENWICH	$5,874.16
GRIFFIN	$4,225.19
HARTFORD	$6,694.01
HOSP OF CEN. CT	$4,170.67
HUNGERFORD	$4,100.33
JOHNSON	$3,225.21
LAWRENCE MEM.	$4,520.92
MANCHESTER	$4,842.67
MIDSTATE	$3,900.75
MIDDLESEX	$4,546.39
MILFORD	$3,822.82

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Connecticut

NEW MILFORD	$5,975.37
NORWALK	$5,803.77
ROCKVILLE	$3,679.08
SAINT FRANCIS	$6,228.67
SAINT MARY	$5,533.39
SAINT RAPHAEL	$5,428.70
SAINT VINCENT	$5,190.27
SHARON	$3,447.13
STAMFORD	$4,568.92
WATERBURY	$4,868.02
WINDHAM	$3,828.28
YALE-NEW HAVEN	$6,903.18

Effective January 1, 2012, the per diem rate for general acute care children's hospitals, defined as any hospital which, on January 1, 2012, is within the class of hospitals licensed by the Department of Public Health as children's general hospitals, shall be:

	Per Diem
CONNECTICUT CHILDREN'S MEDICAL CENTER (CCMC)	$2,172.85

Effective January 1, 2012, inpatient hospital psychiatric per diem rates for children under 19 years of age will differentiate between medically necessary acute days and medically necessary discharge delay days. Such rates shall be as follows:

	Child Psychiatric Inpatient Per Diem	
	Medically Necessary Acute Days	Medically Necessary Discharge Delay Days
BACKUS	$677.78	$576.11
BRIDGEPORT	$765.34	$650.54
BRISTOL	$721.54	$613.31
CCMC	$1,730.25	$1,470.71
DANBURY	$742.18	$630.86
DAY KIMBALL	$623.80	$530.23
DEMPSEY	$776.29	$659.85
GREENWICH	$649.78	$552.31
GRIFFIN	$728.08	$618.87
HARTFORD	$854.66	$726.46

HOSP OF CEN. CT	$735.41	$625.10
HUNGERFORD	$752.45	$639.58
JOHNSON	$766.01	$651.11
LAWRENCE MEM.	$697.32	$592.72
MANCHESTER	$722.69	$614.29
MIDSTATE	$827.74	$703.58
MIDDLESEX	$776.67	$660.17
NORWALK	$785.51	$667.69
SAINT FRANCIS	$718.33	$610.58
SAINT MARY	$664.74	$565.03
SAINT RAPHAEL	$773.84	$657.76
SAINT VINCENT	$822.52	$699.14
STAMFORD	$781.03	$663.88
WATERBURY	$831.38	$706.67
YALE-NEW HAVEN	$1,003.39	$852.88

Such per diem rates are inclusive of all hospital service fees and hospital-based professional services. Payment shall continue as long as placement in this level of care is appropriate. Pediatric psychiatric inpatient payments and patient days shall be excluded from Medicaid Cost Per Discharge settlement.

Effective January 1, 2012, per diem rates for intermediate Child and Adolescent Rapid Emergency Stabilization Services (CARES) provided in a designated general hospital unit with an approved Certificate of Need that specifically provides for the operation of a CARES unit for such services shall be:

Days 1-3: $1,175.00 per diem

The CARES program provides psychiatric triage, a continuum of screening and assessment services, crisis intervention, brief active treatment, short-term stabilization, and disposition planning.

The per diem rates are inclusive of all hospital service fees and hospital-based professional services. Payment shall be limited to 3 days, except that for those children authorized by the Department for admission to the Connecticut state operated psychiatric residential treatment facility or to a specialized out-of-state residential or hospital facility, payment shall be permitted beyond the 3-day limit at the CARES rate of $1,175.00 per day until the child is transferred. The Department may otherwise authorize payment beyond the 3-day limit on an exception basis based on the clinical needs of the child.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Connecticut

Effective January 1, 2012, supplemental reimbursement for general acute care hospitals with a child/adolescent psychiatric unit and private psychiatric hospitals shall be made on a one-time lump sum basis.

(a) A supplemental payment will be made to in-state general and psychiatric hospital providers of child psychiatric inpatient services. One-time supplemental payments to eligible providers shall be made from a pool of funds in the amount of $934,000. Each eligible hospital's share of the supplemental payment pool shall be equal to that hospital's pro rata share of the total Medicaid inpatient revenues of all eligible hospitals in the aggregate for CY 2011.

Effective January 1, 2012, supplemental reimbursement for general acute care hospitals with a child/adolescent psychiatric unit and private psychiatric hospitals shall be made annually as follows:

(a) Supplemental payments to in-state general and psychiatric hospital providers of psychiatric inpatient services shall be paid from a pool of funds of $934,000 per year to hospitals that meet performance initiative measures approved by the Department. The initial performance period shall be calendar year 2012 with payments made in the quarter ending June 30th of the following year. Payments shall continue to be paid to hospitals based on their measured performance during the preceding calendar year. Performance data will be calculated using authorization data from the Administrative Service Organization and/or claims data.

(b) The participating hospitals shall be awarded a share of the performance fund based on:
Goal 1: Ability to further reduce or maintain already efficient lengths of stay during the performance period (2 points)
Goal 2: Reduce or maintain already satisfactory 7 and 30-day re-admission rates (1 point)
Goal 3: Incorporate Wellness and Recovery Planning
(1 point)

(c) To calculate each hospital's performance payment, a hospital's points are summed and multiplied by the number of discharges for the hospital during the performance period. This product weights the amount they earn by discharge volume. Each hospital's payout percentage is its product divided by the sum of all the hospitals' products. Each hospital's performance payment will be the payout percentage multiplied by the total available fund of $934,000.

Effective June 1, 2010, per diem rates for intermediate duration acute psychiatric care provided in a designated general hospital unit certified by the state Department of Mental Health and Addiction Services for such services shall be:

Days 1-29:	$900
Days 30+:	$825

Such per diem rates are inclusive of all hospital service fees and hospital-based professional services. Payment shall continue as long as placement in this level of care is appropriate. Inpatient stays that include transfer to intermediate duration acute psychiatric care beds from other inpatient psychiatric beds within a hospital shall be paid based on the intermediate duration psychiatric care rate schedule for all days. Intermediate duration psychiatric care payments and patient days shall be excluded from Medicaid Cost Per Discharge 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.

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.

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

(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 (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; and (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; and (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.

(2 A) Supplemental Reimbursement for Inpatient Hospital Services. Supplemental payments to eligible hospitals shall be made from a pool of funds in the amount of $131 million per year. The payments shall be made periodically on a lump-sum basis throughout each fiscal year. The supplemental payment program shall be in effect for services furnished from July 1, 2011 through and including June 30, 2013. Payment for the quarter ending September 30, 2011 will be issued during the quarter ending December 31, 2011. All subsequent payments will be issued in the quarter for services furnished during the quarter.

(a) Hospitals eligible for supplemental payments under this paragraph are short-term general hospitals other than short-term Children's General Hospitals and short-term acute care hospitals operated exclusively by the State, other than a short-term acute care hospital operated by the State as a receiver.

(b) Each eligible hospital's share of the supplemental payment pool shall be equal to that hospital's pro rata share of the total Medicaid inpatient revenues of all eligible hospitals in the aggregate. For purposes of this supplemental payment, "Medicaid inpatient revenues" means payments for Medicaid inpatient hospital services provided in federal fiscal year 2009 to each eligible hospital up to $20 million per year per hospital as reported in each hospital's filing with the State of Connecticut Office of Health Care Access.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Connecticut

3) Private Psychiatric Hospitals for individuals under 22 and over 64 years of age:

a. Effective July 1, 2011, the per diem rate for acute psychiatric care provided in a private psychiatric hospital shall be $814.65.

Effective January 1, 2012, per diem rates for private psychiatric hospitals will differentiate between adults 19 years of age and older and children 18 years of age and younger. Additionally, the adult psychiatric per diem rates will differentiate between lengths of stays less than 30 days and stays of 30 days or more. Additionally, the child psychiatric per diem rates will differentiate between medically necessary acute days and medically necessary discharge delay days.

Effective January 1, 2012, per diem rates for private psychiatric hospitals shall be:

	Adult Per Diem		Child Per Diem	
	Days 1-29	Days 30+	Acute Days	Discharge Delay Days
NATCHAUG	$814.65	$692.45	$829.96	$705.47

b. The per diem rate is inclusive of all hospital service fees and hospital-based professional services. Payment shall continue as long as placement in this level of care is appropriate.

c. The payments and patient days shall be excluded from Medicaid TEFRA cost per discharge settlement.