Table of Contents

State/Territory Name: CT

State Plan Amendment (SPA) #: 19-0011

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Financial Management Group

June 17, 2019

Roderick L. Bremby, Commissioner
Department of Social Services
55 Farmington Avenue 9th Floor
Hartford, CT 06105

RE: Connecticut 19-0011

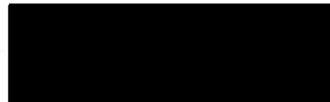
Dear Commissioner Bremby:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 19-0011. This amendment makes changes to the 3M All Patient Refined Diagnosis-Related Group (APR-DRG) reimbursement methodology for inpatient hospital services. Effective April 15, 2019 to December 31, 2019, it adds a state-specific adjustment factor to the APR-DRG base payment calculation with the implementation of version 36 of the APR-DRG grouper. The amendment also specifies that subsequent grouper version and adjustment factor will be implemented each January.

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. We are pleased to inform you that Medicaid State plan amendment 19-0011 is approved effective April 15, 2019. 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,



Kristin Fan,
Director

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

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 19-0011

2. STATE: CT

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

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

4. PROPOSED EFFECTIVE DATE: April 15, 2019

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 and 42 CFR 440.10 and 447.253(a), (b), and (c)

7. FEDERAL BUDGET IMPACT:
FFY 2019 $63.6 million
FFY 2020 $138.4 million

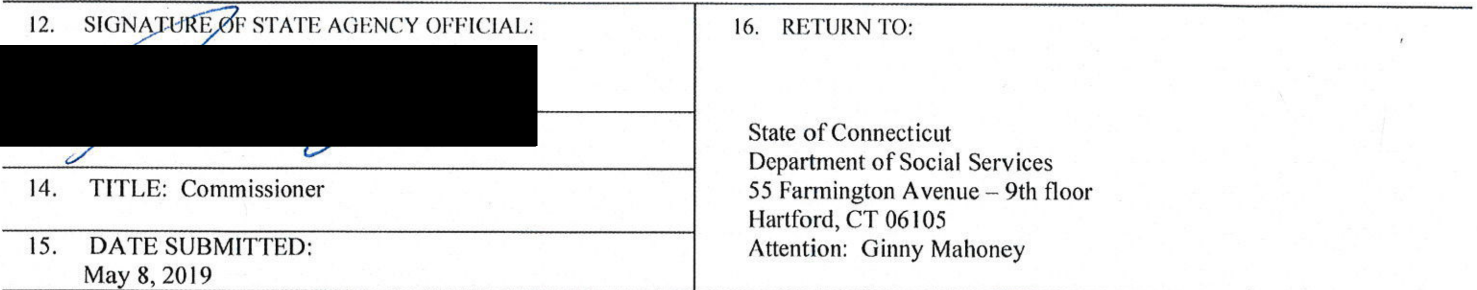
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Page 1(i) and 1(ix)
Attachment 4.19-A, Pages 1(i)a & 1(i)b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If applicable)
Attachment 4.19-A, Pages 1(i) and 1(ix)
New

10. SUBJECT OF AMENDMENT: Effective April 15, 2019, this SPA amends Attachment 4.19-A of the Medicaid State Plan to include an adjustment factor in the 3M APR-DRG reimbursement methodology to make overall DRG payment levels under the most recent grouper comparable to overall payment levels under the prior grouper. A separate adjustment factor will be calculated for each peer group: public, children's, and private acute care hospitals. The applicable adjustment factor is intended to offset the overall change in weights in the most recent DRG grouper version relative to the previous version. This SPA also specifies that each new grouper version and updated adjustment factor will be implemented each January 1st. DSS estimates that this SPA will increase federal expenditures by approximately $63.6 million in FFY 2019 and $138.4 million in FFY 2020. However, because this SPA is designed to offset the overall change in weights from the most recent grouper version to the prior grouper version, after implementation of this SPA, there is no significant change in the level of expenditures compared to the level in place prior to the implementation of the most recent grouper version.

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:

14. TITLE: Commissioner

15. DATE SUBMITTED: May 8, 2019

16. RETURN TO:
State of Connecticut
Department of Social Services
55 Farmington Avenue – 9th floor
Hartford, CT 06105
Attention: Ginny Mahoney

FOR REGIONAL OFFICE USE ONLY

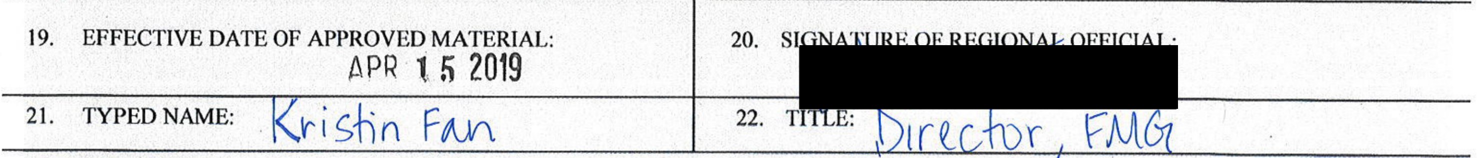
17. DATE RECEIVED:

18. DATE APPROVED: JUN 17 2019

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: APR 15 2019

20. SIGNATURE OF REGIONAL OFFICIAL:



21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

23. REMARKS:

FORM CMS-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Connecticut

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

(1) Inpatient Hospital Services - DRG Payment Methodology

Effective for admissions on or after January 1, 2015, the DRG reimbursement methodology described in this section applies to all discharges except for psychiatric and rehabilitation services, which will be reimbursed on a per diem basis. The hospital must submit a prior authorization request to the Department of Social Services or its agent for all such inpatient hospital services to qualify for per diem reimbursement. If the department approves such prior authorization request, the discharge shall be reimbursed using the applicable per diem rate established by the department.

Services provided in the emergency room, observation area, or other outpatient departments that are directly followed by an inpatient admission to the same hospital are not reimbursed separately.

For the purposes of this section, "Discharge" means any patient who was discharged at a date subsequent to the date admitted to the hospital for treatment as an inpatient, except that it shall also mean such patient admitted and discharged on the same day where such patient:

1. died,
2. left against medical advice, or
3. where a one day stay has been deemed appropriate subject to utilization review.

A. DRG Payment

The Department shall pay for hospital inpatient services on a fully prospective per discharge basis using DRG-based discharge payments. Diagnosis related groups will be assigned using the most recent version of the 3M All Patient Refined Diagnosis-Related Grouper (APR-DRG) with each new grouper version released by 3M being implemented the subsequent January 1st. Payments shall be capped at the amount of charges.

1. The DRG discharge payment is comprised of the DRG base payment plus any outlier payment that may be made when the charges for the stay exceed the outlier threshold. (See detailed description of outlier payment methodology below.)
2. The DRG base payment is calculated by multiplying the hospital-specific base rate by the DRG relative weight and then multiplying that result by an adjustment factor described in number 4 below. (See base rate table below.)
3. The DRG relative weights are 3M APR-DRG National Weights.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Connecticut

4. Effective from April 15, 2019 through December 31, 2019, a state-specific adjustment factor will be added to the DRG base payment calculation. The adjustment factor will be calculated to scale the relative weights under grouper version 36 to be comparable overall to the relative weights under grouper version 35. The state-specific adjustment factor will be calculated for each peer group (children's hospitals, public acute care general hospitals, and private acute care general hospitals) as follows:

    a. Claims data for discharges between January 1, 2018 and September 30, 2018 that processed under grouper version 35 will be obtained from the MMIS.

    b. An aggregate target value is calculated using the claims data from step (a) and is determined by pricing the claims utilizing grouper version 35 and multiplying the applicable DRG weights by the 2018 hospital-specific base rate. This value will be the numerator under step (d) below.

    c. For grouper version 36, an aggregate value is calculated using the claims data from step (a) and is determined by pricing the data utilizing grouper version 36 and multiplying the applicable DRG weights by the 2018 hospital-specific base rate. This value will be the denominator under step (d) below.

    d. The state-specific adjustment factor is calculated by dividing the total of step (b) by the total of step (c).

5. Beginning January 1, 2020 and effective each January 1st thereafter, the state-specific adjustment factor will be adjusted to scale the relative weights of the most recent grouper version to be comparable overall to the relative weights of the previous version and state-specific adjustment factor. Updates to the state-specific adjustment factor will be calculated for each peer group (children's hospitals, public acute care general hospitals, and private acute care general hospitals) as follows:

    a. Claims data for discharges between the previous January 1 and September 30 are obtained from the MMIS.

    b. An aggregate target value is calculated using the claims data from step (a) and is determined by pricing the claims utilizing the most recent grouper version and multiplying the applicable DRG weights by the most recent hospital-specific base rate by the current state specific adjustment factor. This value will be the numerator under step (d) below.

c. For the new DRG grouper version, an aggregate value is calculated using the claims data from step (a) and is determined by pricing the data utilizing the new grouper version and multiplying the applicable DRG weights by the most recent hospital-specific base rate. This value will be the denominator under step (d) below.

d. The new state-specific adjustment factor is calculated by dividing the total of step (b) by the total of step (c).

J. Out-of-State and Border Hospital Reimbursement

1. Standard Payment Methodology. Except as otherwise provided below, each out-of-state and border hospital will be paid as follows and which is also the minimum amount to be paid:

   a. Except as otherwise provided in b. and c. below, in reimbursing for inpatient hospital services to out-of-state and border hospitals, the Department shall pay a DRG base payment of $7,505.68 multiplied by the applicable DRG weight for the discharge multiplied by the adjustment factor described below plus any applicable outlier payment. Effective April 15, 2019 through December 31, 2019, the state-specific adjustment factor for the in-state private acute care general hospital peer group will be incorporated into the DRG base payment calculation as described in subsection A4 of the DRG payment section of Attachment 4.19-A of the Medicaid State Plan. Beginning January 1, 2020 and effective each January 1st thereafter, the state-specific adjustment factor will be updated as described in subsection A5 of the DRG payment section of Attachment 4.19-A of the Medicaid State Plan. Organ acquisition costs for kidneys, livers, hearts, pancreas and lungs are reimbursed at the lower of the statewide average of actual average acquisition cost using the in-state Medicare cost reports, inflated by the inpatient hospital market basket as published by CMS, or actual charges. The Medicare cost report for the period two years prior to the current state fiscal year, submitted to the Office of Health Strategy, formerly the Office of Health Care Access, by July 1st will be used in the calculations. If there is no in-state average for a particular organ, the applicable hospital's most recent Medicare cost report will be used to compute actual average acquisition cost.

   b. Out-of-state and border hospitals shall be paid a per diem rate of $1,050.00 for psychiatric discharges.

   c. Out-of-state and border hospitals shall be paid a per diem rate of $1,370.00 for rehabilitation discharges.

2. Hospital Option. Each out-of-state and border hospital may request to have its rate set based on its home state Medicaid base rate excluding add-ons.

3. Services Not Available In-State. If the Department determines that a service is not available in Connecticut, the Department may pay an out-of-state or border hospital up to a maximum of the provider's usual and customary charges.