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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations (CMSO)

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

FEB 1 8 2010

RE: TN 09-003

Dear Mr. Starkowski:

We have reviewed the proposed amendment to Attachment 4.19-A, 3.1-A, and 3.1-B of your Medicaid State plan submitted under transmittal number (TN) 09-003. This amendment modifies the payment methodology for general acute care inpatient hospital services. Specifically, it adjusts the payment rate for any hospital acquired condition (HAC) that meets the criteria established in section 1(k) of the addendum to Attachments 3.1-A and 3.1-B, Page 1(b).

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 09-003 is approved effective April 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,

[redacted]

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

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

1. TRANSMITTAL NUMBER: 09-003
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
4/01/2009

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 5001(c) of the Deficit Reduction Act of 2005

7. FEDERAL BUDGET IMPACT:
a. FFY 2009 - $510,000
b. FFY 2010 - $1,035,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachments 3.1-A, Addendum page 1a-1c, 3.1-B, Addendum page 1a-1c and Attachment 4.19A Pages 1, 1a and 1b

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If applicable)
Attachments 3.1-A, Addendum page 1a-1c, 3.1-B, Addendum page 1a-1c, Attachment 4.19A

10. SUBJECT OF AMENDMENT: Under state plan amendment 09-003, the Department of Social Services proposes to amend Attachments 3.1-A, 3.1-B, and 4.19A of the Connecticut Medicaid State Plan to comply with the requirements of Section 8 of the Deficit Mitigation Measure for the Fiscal Year Ending June 30,2009. Effective April 1st 2009, the Department will prohibit or reduce reimbursement for general acute care hospital admissions during which a patient experiences a "never event" or acquires a hospital acquired condition or that results from a "never event" or hospital acquired condition that is among the list of non-reimbursable hospital acquired conditions established pursuant to section 5001(c) of the Deficit Reduction Act (DRA) of 2005. This amendment is projected to result in $510,000 in federal budgetary savings in FFY09 and $1,035,000 in federal budget savings in FFY10. Please note that the Federal budget Impact calculations assume 60% federal match.

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
_X_OTHER, AS SPECIFIED:
Comments, if any, to follow.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
Michael P. Starkowski

14. TITLE:
Commissioner, Department of Social Services

15. DATE SUBMITTED:
June 24, 2009

16. RETURN TO:
State of Connecticut
Department of Social Services - 11th floor
25 Sigourney Street
Hartford, CT 06106-5033
Attention: Ginny Mahoney

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: 02-18-10

PLAN APPROVED – ONE COPY ATTACHED

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

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: William Lasowski

22. TITLE: Deputy Director, CMSO

23. REMARKS:

FORM HCFA-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) 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. This federal methodology shall apply except 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, 2009, 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 (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).

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Connecticut

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.

(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%).

State: CONNECTICUT

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

1. Inpatient Hospital Services - With Limitations as follows:

   a. Diagnostic, therapeutic or treatment procedures, and inpatient hospital stays for experimental, cosmetic, research, social or educational purposes;

   b. Any services or items furnished for which the provider does not usually charge;

   c. The day of discharge or transfer;

   d. Leave of Absence (LOA) or Pass without medical permission;

   e. Leave of Absence (LOA) or Pass with and without Medical Permission, when the Title XIX patient is out of the hospital at the time of the census count (12 Midnight);

   f. Emergency room services provided on the same day as inpatient admission;

   g. Hospital inpatient stay is not covered when the following procedures or services are performed:

      1. Tuboplasty and sterilization reversal

      2. Inpatient charges related to autopsy

      3. All services or procedures of a plastic or cosmetic nature performed for reconstructive purposes, including but not limited to the following: lipectomy, hair transplant, rhinoplasty, dermabrasion, chemabrasion.

      4. Transsexual surgical procedures for gender change or reassignment or treatment preparatory to transsexual procedures (e.g. hormone therapy and electrolysis).

      5. The Department shall pay for surgical services necessary to treat morbid obesity when another medical illness is caused by, or is aggravated by, the obesity. Such illnesses shall include illnesses of the endocrine system or the cardio-pulmonary system, or physical trauma associated with the orthopedic system. For the purposes of this section, "morbid obesity" means "morbid obesity" as defined by the International Classification of Diseases (ICD, as amended from time to time.

State: CONNECTICUT

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

h. The Department will not pay for drugs included in the Drug Efficacy Study Implementation (DESI) Program that the Food and Drug Administration has proposed to withdraw from the market in a notice of opportunity for hearing.

i. Admissions and day(s) of care that do not meet established requirements for medically necessary acute care inpatient hospital services.

j. Payment will be denied for general hospital inpatient recipients if the Department determines that the medical care, treatment or service does not or did not meet the established medically necessary and/or utilization review standard in accordance with generally accepted criteria and standards of medical practice, or if they do not or did not comply with the other policies, procedures, conditions and limitations established by the Department. This determination may be made at the time of prior authorization, preadmission review, or retrospective review. The fact that a denial was not made at an earlier stage shall not preclude such a determination at a later stage. The Department is entitled to disallow the entirety or any portion of the stay and services provided they do not meet the medically necessary or utilization review standard.

k. Approved inpatient hospital rates shall be reduced or eliminated at the time of cost settlement for admissions during which a hospital acquired condition occurs. For the purposes of this section, hospital-acquired conditions means those conditions identified as non-payable by Medicare pursuant to Section 5001 (c) of the Deficit reduction Act of 2005. The methodology for reducing the per discharge case rate is established in 4.19A, page 1(i).

State: CONNECTICUT

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

2. Outpatient Hospital Services

   a. No more than one (1) visit per day to the same outpatient clinic.

   b. No more than one (1) psychiatric/psychological reevaluation per year per hospital for the same recipient.

3. Other Laboratory and X-Ray Services

   No limitation on services.

State: CONNECTICUT

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

1. Inpatient Hospital Services - With Limitations as follows:

   a. Diagnostic, therapeutic or treatment procedures, and inpatient hospital stays for experimental, cosmetic, research, social or educational purposes;

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FEB 1 8 2010

State: CONNECTICUT

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
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   No limitation on services.

OS Notification

State/Title/Plan Number:	**Connecticut 09-003**	
Type of Action:	**SPA approval**	
Required Date for State Notification:	**March 1, 2010**	
Fiscal Impact:	**FFY 2009**	**($510,000) FFP**
	FFY 2010	**($1,035,000) 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 April 1, 2009, this amendment modifies the payment methodology for general acute care inpatient hospital services. Specifically, it adjusts the payment rate for any hospital acquired condition (HAC) that meets the criteria established in section 1(k) of the addendum to Attachments 3.1-A and 3.1-B, Page 1(b). The State will reduce the payment rate using the same methodology as Medicare. During the annual cost settlement all Medicaid claims will run through a Medicare diagnosis-related grouper to determine the Medicare amount with or without the "Present on Admission (POA)" indicator. For claims that would result in Medicare payment reduction, the State will calculate the percentage reduction and apply it to the Medicaid allowed amount per discharge for fee-for-service cases**

Other Considerations: **This amendment has not generated significant outside interest and 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**