Table of Contents

State/Territory Name: CT

State Plan Amendment (SPA) #: 14-010

This file contains the following documents in the order listed:

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

JUN 11 2014

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

RE: Connecticut 14-010

Dear Mr. Bremby:

We have reviewed the proposed amendment to Attachments 4.19-A, of your Medicaid State plan submitted under transmittal number (TN) 14-010. This amendment proposes a technical correction to the State Plan language. Specifically, it clarifies the inpatient case rates listed in the plan language.

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 14-010 is approved effective January 1, 2014. 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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR 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: 14-010
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
01/01/2014

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

7. FEDERAL BUDGET IMPACT:
a. FFY 2014 $0
b. FFY 2015 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A Page 1 (ii) and (iii)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If applicable)
Attachment 4.19-A Page 1 (ii) and (iii)

10. SUBJECT OF AMENDMENT:
This amendment will implement a clarification of the inpatient case rates. Effective January 1, 2014, the case rates for the hospitals that qualify for the disproportionate share hospital (DSH) add-on will reflect the base case rate in the State Plan. This will enable the State to update the per diem rates to reflect the applicable DSH add-on percentages each year for the hospitals that qualify. The SPA is intended to clarify the original intent of the existing State Plan language so that there is no ambiguity regarding the DSH add-on. The add-on is covered in the State Plan under attachment 4.19A, page 3, section 4. Therefore, it should not be included in the case rates listed in the State Plan on pages 1(ii) and (iii) in section 1.

11. GOVERNOR'S REVIEW (Check One):

_X_ GOVERNOR'S OFFICE REPORTED NO COMMENT
__COMMENTS OF GOVERNOR'S OFFICE ENCL
__NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
__OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

TYPED NAME: Roderick L. Bremby

14. TITLE: Commissioner

15. DATE SUBMITTED:
March 25, 2014

16. RETURN TO:

State of Connecticut
Department of Social Services
25 Sigourney Street
Hartford, CT 06106-5033

Attention: Ginny Mahoney, Medical Policy

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: JUN 11 2014

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JAN 01 2014

20. SIGNATUR REGIONAL OFFICIAL:

21. TYPED NAME: Penny Thompson

22. TITLE: Deputy Director, Policy & Financial Mgt. CMCS

23. REMARKS:

FORM HCFA-179 (07-92)

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, 2014, inpatient hospital target amounts per discharge excluding DSH add-on for hospitals qualifying under page 3, section 4, shall be:

	Target
BACKUS	$4,201.23
BRIDGEPORT	$5,356.54
BRISTOL	$3,590.39
DANBURY	$5,377.29
DAY KIMBALL	$3,866.90
DEMPSEY	$10,142.98
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
NEW MILFORD	$5,975.37
NORWALK	$5,803.77

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Connecticut

ROCKVILLE	$3,679.08
SAINT FRANCIS	$5,598.69
SAINT MARY	$5,052.14
SAINT VINCENT	$5,190.27
SHARON	$3,447.13
STAMFORD	$4,568.92
WATERBURY	$4,868.02
WINDHAM	$3,828.28
YALE-NEW HAVEN	$5,807.17

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 September 12, 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