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State/Territory Name: CT

State Plan Amendment (SPA) #: 16-0008

This file contains the following documents in the order listed:

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

DEC 14 2016

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

RE: Connecticut 16-0008

Dear Commissioner Bremby:

We have reviewed the proposed amendment to Attachments 4.19-A and 4.19B of your Medicaid State plan submitted under transmittal number (TN) 16-0008. This amendment reimburses Long Acting Reversible Contraceptive (LARC) devices separately from the inpatient DRG payment. Specifically, from April 15, 2016 to June 30, 2016 reimbursement will be based on an interim add-on outpatient fee schedule rate (revenue code RCC 253-take home drugs) when LARC devices are provided as part of an inpatient obstetrical delivery.

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 16-0008 is approved effective April 15, 2016. 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 or Robert Cruz at (617) 565-1257.

Sincerely,

[redacted]

Kristin Fan
Director

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: 16-0008
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, 2016

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:
Sections 1905(a)(1) and (a)(2)(A) of the Social Security Act and 42 CFR 440.10 and 440.20

7. FEDERAL BUDGET IMPACT:
a. FFY 2016 $18,000
b. FFY 2017 $47,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A Page 1v
Attachment 4.19-B Page 1

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If applicable)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

10. SUBJECT OF AMENDMENT: Effective April 15, 2016, this SPA amends Attachments 4.19-A and 4.19-B of the Medicaid State Plan to reimburse hospitals for Long Acting Reversible Contraceptive (LARC) devices separately from the inpatient All Patient Refined Diagnosis Related Group (APR-DRG) when the LARC is provided as part of the inpatient obstetrical delivery. This SPA expands access to LARC services for beneficiaries, which are anticipated to increase costs by the amounts listed above. However, when accounting for the impact of this SPA on other services, this SPA is expected to result in cost savings by enabling beneficiaries to reduce unplanned pregnancies.

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:
[redacted]

13. TYPED NAME: Roderick L. Bremby

14. TITLE: Commissioner

15. DATE SUBMITTED: June 29, 2016

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: DEC 14 2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: APR 15 2016

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

23. REMARKS:

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Connecticut

2. Under the transfer payment methodology, the hospital the member is transferred from shall be reimbursed the lesser of the DRG base payment and the transfer DRG base payment. The transfer DRG base payment equals the initial DRG base payment divided by the DRG average length of stay multiplied by the sum of one plus the actual calculated length of stay not to exceed the DRG base payment.
3. The hospital to which the member is transferred shall be reimbursed the full DRG discharge payment without a reduction due to the transfer.

G. Third Party Payments

Any applicable third party payments are treated as offsets from allowed payments.

H. Payments Outside DRG Base Payment

The following payments are made outside of, and in addition to, the DRG base payment:

1. Direct graduate medical education is reimbursed as a prospective quarterly pass through. Payment for the state fiscal year is based on the Medicaid inpatient percentage of full-time equivalent (FTE) residents multiplied by the approved amount for resident costs, as defined in this section, using the hospital's Medicare cost report, inflated by the inpatient hospital market basket published by CMS. The Medicare cost report for the period two years prior to the current state fiscal year, submitted to the Office of Health Care Access by July1st will be used in the calculations. The approved amount for resident costs is based on worksheet E-4, line 19, column 3; total days are based on worksheet S-3, part I, column 8 excluding nursery days; and the inpatient percentage is based on inpatient revenue divided by total revenue from worksheet G-2, line 28, columns 1 and 3. Behavioral health days for children under age 19 and nursery days are excluded from Medicaid days in the Medicaid inpatient percentage.
2. 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 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 Care Access by July1st will be used in the calculations.
3. Long Acting Reversible Contraceptives (LARCs) will be reimbursed separately from the APR-DRG payment. A separate outpatient claim may be submitted by the hospital for reimbursement under Revenue Center Code 253 in conjunction with the following codes: J7297, J7298, J7300, J7301 and J7307. Reimbursement for these codes will be based on the CMS approved outpatient hospital reimbursement methodology as described in Attachment 4.19-B.

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

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES–OTHER TYPES OF CARE

(2) (a) Outpatient hospital services – The agency reimburses outpatient hospital services using both fixed fees and cost to charge ratios. The agency's fixed fees were set as of April 15, 2016 and are effective for services on or after that date. Fixed fees are published on the Department's website at www.ctdssmap.com. Fixed fees are paid for various categories of outpatient hospital services, including, but not limited to: diagnostic laboratory services, imaging, therapies, group tobacco cessation counseling, behavioral health, and various other categories of service according to the revenue center codes listed in the fee schedule. For revenue center codes not listed on the fee schedule, the rate for each code is based on the hospital-specific cost to charge ratio for each applicable ancillary or outpatient department as designated by the hospital and reported on the hospital's fiscal year 2013 cost report filing, as determined by the Department. The rate schedule is sent to each hospital and is revised annually (July 1) based on the most recently filed cost report. Rates for outpatient hospital services are not reconciled to actual costs.

There are higher fees for outpatient hospital behavioral health services that meet special access and quality standards as enhanced care clinics (ECCs), as noted on the hospital-specific schedule for each hospital that has an ECC. ECCs must accept all (100%) telephonic and walk-in referrals that present during business hours. All referrals must be screened by a trained intake worker or clinician and triaged to determine whether the referral is emergent, urgent or routine. A clinician must evaluate a client who presents at the clinic with an emergent condition within two (2) hours. Clients that undergo telephonic or walk-in screening and are determined to be in urgent need of services must be offered an appointment for an urgent face-to-face clinical evaluation with a clinician to take place within two (2) calendar days of the screening. Clients that undergo telephonic or walk-in screening and are determined to have routine needs must be offered an appointment for a routine face-to-face clinical evaluation with a clinician to take place within 14 calendar days of the screening. ECCs must have at least nine (9) extended hours per week beyond routine business hours of 8:00 AM to 5:00 PM. ECCs have a valid Letter of Agreement with the Department that holds them accountable to the quality standards and access standards receive the enhanced rate for all routine outpatient services provided. The state monitors the access standards on a routine basis and provides access standard reports to the providers on a quarterly basis. The state has established a process for providers to submit corrective action plans (CAPs) if they do not meet the access standards for any reason except in increase in volume in excess of 20% compared to the same quarter of the previous year. ECCs must electronically register appointments made with the Administrative Services Organization (ASO). This process allows for an automated process to track access standards for routine cases. The state also utilizes a mystery shopper process to track access standards. The state also does on-site chart reviews to determine if providers are in compliance with quality standards and the urgent and emergent access standards. As a result of the on-site reviews, CAPs will be required from providers who do not meet quality or access standards reviewed. Fees for services provided to individuals 18 years of age and over are 95% of the published fee for ECCs.

Except as otherwise noted in the plan, state developed fee schedules and rate methods are the same for both governmental and private providers.