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

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

Financial Management Group

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

RE: Connecticut 18-0018-A

November 9, 2018

Dear Commissioner Bremby:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 18-0018-A. Effective February 1, 2018, this amendment proposes a Certified Public Expenditure (CPE) Cost Protocol for Dispropotionate Share Hospital (DSH) reimbursement to public acute care hospitals.

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 18-0018-A is approved effective February 1, 2018. 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]

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: 18-0018-A
2. STATE: CT

11. 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

11. PROPOSED EFFECTIVE DATE:
February 1, 2018

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 2018 $0
FFY 2019 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Pages 17 – 18(a)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If applicable)
Attachment 4.19-A, Pages 17 – 18(a)

10. SUBJECT OF AMENDMENT: Effective February 1, 2018, SPA 18-0018– A amends Attachment 4.19-A of the Medicaid State Plan to clarify the existing description of the disproportionate share hospital (DSH) payment methodology for public acute care hospitals (John Dempsey Hospital, which is operated by the University of Connecticut). As described in the SPA pages, it adds details regarding initial claims and settlement as well as clarifying that the DSH claims are funded using a certified public expenditure (CPE) methodology.

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:
March 27, 2018

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: NOV 09 2018

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: FEB 01 2018

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMG

23. REMARKS: Pen and ink changes in boxes 1, 8, 9 and 10 per state request.

FORM CMS-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Connecticut

(10) Additional Disproportionate Share Claims for Public Acute Care Hospitals (short-term General Hospitals) which provide Uncompensated Care under Section 1923 of the Social Security Act.

Disproportionate share claims are made for any qualifying public acute care hospital lawfully operating within the state that provides uncompensated care.

CRITERIA – In order to qualify as a disproportionate share hospital under this section, a hospital must meet the following conditions:

1. Be a lawfully operating acute care hospital within the state providing uncompensated care services.

2. Each hospital must meet the requirements of Section 1923(d) of the Social Security Act.

3. Each hospital must be publicly owned and operated.

UNCOMPENSATED CARE (UCC) is the difference between Costs and Payments associated with providing inpatient and outpatient hospital services to (1) Medicaid individuals (Medicaid shortfall) and (2) individuals with no source of third party coverage for the services they received (uninsured costs).

COST is calculated using cost center-specific per diems and ratios of cost to charges (RCC) from the Medicare cost report (MCR) and hospital's data to determine the cost of providing inpatient and outpatient services.

The per diem costs are calculated as costs for each routine cost center (MCR worksheet C, Part I, Column 5, cost centers 30-43 including subscripts) divided by corresponding days (MCR worksheet S-3, Part I, Column 8, cost centers 30-43 including subscripts).

The RCCs are calculated as costs for each ancillary and outpatient cost center (MCR worksheet C, Part I, Column 5, cost centers 50-76 and 90-93 including subscripts) divided by corresponding charges (MCR worksheet C, Part I, Column 8, cost centers 50-76 and 90-93 including subscripts).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Connecticut

MEDICAID SHORTFALL - The difference between Costs and Payments for Medicaid individuals.

Medicaid days for each cost center are multiplied by the applicable per diem cost and the results are summed to calculate total per diem cost.

Medicaid charges for each ancillary cost center are multiplied by the applicable RCC and the results are summed to calculate total ancillary cost.

Payments are amounts made by or on behalf of patients and include payments made by third parties such as other insurance related to Medicaid inpatient and outpatient services, Medicaid claims payments made through the MMIS, and other Medicaid payments for Medicaid inpatient and outpatient services furnished during the year such as graduate medical education and supplemental payments.

UNINSURED COSTS – The difference between Costs minus Payments for uninsured individuals. Uninsured are self pay and self insured patients as well as individuals with no source of third party coverage for the inpatient and outpatient hospital services provided.

Uninsured days for each cost center are multiplied by the applicable per diem cost and the results are summed to calculate total per diem cost.

Uninsured charges for each ancillary cost center are multiplied by the applicable RCC and the results are summed to calculate total ancillary cost.

Payments for the uninsured are the amount received during the state plan year made by or on behalf of patients and payments made by third parties related to uninsured inpatient and outpatient hospital services. It includes payments received during the year under Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens but not payments, funding, or subsidies made by the state or a unit of local government such as a state-only program.

CERTIFICATION - The appropriate official of the governmentally-operated hospital will sign the certification statement on the Governmentally-Operated Hospital UCC. A certification will be signed for each of the three times the limit for the initial DSH claim is calculated as described below under "Reconciliation".

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Connecticut

RECONCILIATION – The federal limit (the limit) established under the Omnibus Budget Reconciliation Act of 1993 or Section 1923 of the Social Security Act using protocols established in the DSH Audit procedures developed by CMS for the cost report of the initial DSH claim will be computed for each governmentally-operated hospital three times:

1. Initial DSH claim based on the cost report(s), days, charges, and other program data for the period two years prior. This calculation will be increased by the Medicare Economic Index and may include a further adjustment to reduce the calculated limit to estimate the limit for the current period if deemed appropriate due to structural changes. The amount calculated is divided by four to determine the quarterly claim.

2. Recalculated when the Medicare cost report for the period of the initial payment is filed. The difference between steps 1 and 2 will be a prior period adjustment.

3. Final calculation using finalized Medicare cost report(s) and DSH audit results shown in the federally required independent audit report. DSH audit is based on a 9/30 year end and the public hospital's Medicare cost report is a 6/30 year end therefore the applicable quarterly amounts will be compared to the DSH audit. The difference between the DSH audit and step 2 will be a prior period adjustment.

The DSS will test the calculated disproportionate share payments allocated to each hospital in each year to ensure the payments do not exceed federal limits established under the Omnibus Budget Reconciliation Act of 1993 or Section 1923 of the Social Security Act using protocols established in the DSH Audit procedures developed by CMS.