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State/Territory Name: Connecticut

State Plan Amendment (SPA) #: 20-0001

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 & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

May 15, 2020

Kathleen Brennan, Deputy Commissioner
Department of Social Services
55 Farmington Avenue, 9th Floor
Hartford, CT 06105-3730

RE: Connecticut 20-0001

Dear Deputy Commissioner Brennan:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 20-0001. Effective January 1, 2020, this amendment implements changes to inpatient hospital reimbursement to non-governmental licensed short-term general hospitals.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1923 and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C.

This is to inform you that Medicaid State plan amendment TN 20-0001 is approved effective January 1, 2020. The CMS-179 and the amended plan page(s) are attached.

If you have any additional questions or need further assistance, please contact Novena James-Hailey at (617) 565-1291 or Novena.JamesHailey@cms.hhs.gov.

Sincerely,

[redacted]

Kristin Fan
Director

Enclosures

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: 20-0001

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:
January 1, 2020

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 2020 $23.3 million
FFY 2021 $40.2 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-A, Pages 1(i), 1(i)a, 1(i)b, 1(iii)a, 1(iv), 1(vi), 1(vii)
Attachment 4.19-A, Pages 1(iii)a(i), 1(iii)a(ii), 1(iii)a(iii) and 1(vii)a

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If applicable)
Attachment 4.19-A, Pages 1(i), 1(i)a, 1(i)b, 1(iii)a, 1(iv), 1(vi), 1(vii)
NEW

10. SUBJECT OF AMENDMENT: Effective January 1, 2020, this SPA amends Attachment 4.19-A of the Medicaid State Plan to make changes to inpatient hospital reimbursement, which are required by the state's settlement agreement with in-state non-governmental licensed short-term general hospitals and implementing state legislation in Public Act 19-1 of the December 2019 special session: (1) the statewide diagnosis-related group (DRG) base rate for non-governmental licensed short-term general hospitals increases to $7,063.07 effective January 1, 2020 and will increase by 2.0% per year effective for discharges each subsequent January 1st through and including January 1, 2026; (2) per diem rates for behavioral health and rehabilitation services for non-governmental licensed short-term general hospitals increase by 2.0% per year effective January 1, 2020 and each subsequent January 1st through and including January 1, 2026, and (3) effective for discharges from January 1, 2020 through June 30, 2026, the wage index is 1.2563 for non-governmental licensed short-term general hospitals located in CBSA 14860 (Fairfield county) and 1.2538 for non-governmental licensed short-term general hospitals not located in CBSA 14860. The rate levels in effect on June 30, 2026 will continue at the same levels effective on and after July 1, 2026 unless modified by a future SPA. This SPA also sets the wage index at 1.2575 for in-state governmental licensed short-term general hospitals and in-state licensed short-term children's general hospitals. In addition, this SPA includes clarifying language on other inpatient hospital state plan pages.

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. [redacted]FICIAL:

13. TYPED NAME: Kathleen M. Brennan

14. TITLE: Deputy Commissioner

15. DATE SUBMITTED:
March 31, 2020

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: 03/31/2020

18. DATE APPROVED: 5/15/20

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 01/01/2020

20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]

21. TYPED NAME: Kristin Fan

22. TITLE: Director

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 numbers 4 and 5 below. (See base rate table below.)
3. The DRG relative weights are 3M APR-DRG National Weights.

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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 (incorporating the grouper's DRG assignments) of the most recent grouper version to be comparable overall to the relative weights of the previous version (incorporating the grouper's DRG assignments) 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 (i) the most recent hospital-specific base rate and (ii) the current state specific adjustment factor. This aggregate value will be the numerator under step (d) below.

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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 aggregate 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).

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C.1 Phase-in of State-Wide Base Rate/Peer Groups

The department shall move from the hospital-specific 2015 base rates under Section C. to state-wide base rates for the following designated peer groups: non-governmental licensed short-term general hospitals, governmental licensed short-term general hospitals, and licensed short-term children's general hospitals.

Phase-in of the base rates for the non-governmental licensed short-term general hospitals will be based on the weighted average statewide base rate using 2015 claims data and will occur over four years under the following time table:

Admissions on or after:	Hospital-Specific %	Statewide %
01/01/2017	75%	25%
01/01/2018	50%	50%
01/01/2019	25%	75%
01/01/2020	0%	100%

No phase-in is needed for the other two peer groups as there is only one hospital in each group. However, the following adjustments will be made to the base rates for all peer groups with payments remaining the same in the aggregate:

1. Acuity for 2015 was calculated in accordance with Section B. If the statewide case mix index (CMI) was greater than 0.8356, no refund of the Documentation and Coding Improvement Reserve Recover was necessary. Actual CMI was 0.8797 therefore the starting base rates for 01/01/2017 will be adjusted to account for the differential and maintain revenue neutrality.

2. Original wage index adjustments assigned by Medicare will be incorporated to account for differences in labor cost among counties and will be updated annually effective January 1st of each year for discharges on or before December 31, 2019. The wage index adjustments will be applied to the labor-related share percentage of the base rate established by Medicare, which will be updated annually effective January 1st of each year except as otherwise provided in this paragraph.

3. Indirect medical education will be included for the applicable hospitals using Medicare's formula of c x [(1+r).405-1] where "r" is a hospital's ratio of residents to beds and "c" is a multiplier set by Congress. The calculation will be updated annually using the most recent Medicare cost report as filed by the prior July 1st with the Office of Health Care Access, i.e. the 2015 cost report will be used for the 2017 rates.

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C.2 Peer Group of Non-Governmental Licensed Short-Term General Hospitals

The hospitals in this peer group are subject to the adjustments outlined in subsection C.1 on page 1(iii)a except as noted below.

1. Effective for admissions on or after January 1, 2018, the base rates for this peer group shall increase by 31.65%.

2. Effective for discharges on and after January 1, 2020, the statewide base rate for this peer group shall be $7,063.07 and shall increase an additional 2% effective each subsequent January 1st through and including January 1, 2026. Each annual increase shall be applied to the rates in effect for the immediately preceding calendar year and the rates in effect on June 30, 2026 shall remain in effect for discharges on and after July 1, 2026 unless modified by a future SPA. The rates described above are set forth in the following table:

2020	2021	2022	2023	2024	2025	2026*
$7,063.07	$7,204.33	$7,348.42	$7,495.39	$7,645.30	$7,798.20	$7,954.17

* As noted above, the rate in effect as of June 30, 2026 shall remain in effect for discharges on and after July 1, 2026 unless modified by a future SPA.

3. Effective from January 1, 2020 through June 30, 2026, the wage index shall be 1.2563 for hospitals located in CBSA 14860 and 1.2538 for hospitals not located in CBSA 14860. CBSA stands for Core-Based Statistical Area which is delineated by the U.S. Office of Management and Budget and used by CMS for Medicare purposes. Such wage index shall remain in place on and after July 1, 2026 unless modified by a future SPA.

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C.3 Peer Group of Governmental Licensed Short-Term General Hospitals

This peer group contains one hospital. It is subject to the adjustments outlined in subsection C.1 on page 1(iii)a except as noted below.

1. Effective for discharges on and after January 1, 2020, the base rate shall be $6,522.56.

2. Effective for discharges on and after January 1, 2020, the wage index shall be 1.2575, the original wage index adjustment assigned by Medicare for 2019, unless modified by a future SPA.

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C.4 Peer Group of Licensed Short-Term Children's General Hospitals

This peer group contains one hospital. It is subject to the adjustments outlined in subsection C.1 on page 1(iii)a except as noted below.

1. Effective for discharges on and after January 1, 2020, the base rate shall be $7,930.70.

2. Effective for discharges on and after January 1, 2020, the wage index shall be 1.2575, the original wage index adjustment assigned by Medicare for 2019, unless modified by a future SPA.

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D. Base Rate Adjustments for Hospital Mergers

When two or more hospitals merge to form a different legal entity, the data used to calculate the base rates of the original entities are totaled and used as the basis for determining a rate for the new entity. The same methodology will be used when one hospital purchases another hospital.

E. Outlier Payment Methodology

1. Outlier payments shall be subject to retrospective review by the department on a case-by-case-basis. Outlier payments will be recalculated if and to the extent that the preponderance of evidence on review indicates the claim includes reporting of services that are not medically necessary or non-covered. Cost of services that are not medically necessary or non-covered will not be allowable in the calculation of outlier payments.
2. A target outlier threshold was developed for each DRG based on an adjustment factor multiplied by the sum of: the average charge for a DRG and 1.96 multiplied by the standard deviation of the charges for the DRG. In addition, a minimum threshold of $30,000 is applied.
3. An outlier adjustment factor was developed to target 4.8% of total payments as outlier payments, resulting in an adjustment factor of 0.3375.
4. If the estimated cost of a case is above the resulting threshold, it qualifies as an outlier and 75% of the excess cost will be paid in addition to the APR-DRG payment.
5. The cost of a case is derived by deducting charges for non-covered services and services not reimbursed under the inpatient APR-DRG methodology (such as professional fees, hospital acquired conditions, organ acquisition) from total billed charges. The remaining billed charges for covered services are then converted to cost using a hospital-specific total cost to total charge ratio. The cost to charge ratio excludes medical education costs and is updated annually using the most recent Medicare cost report as filed by the prior July 1st with the Office of Health Care Access.

F. Transfer Payment Methodology

1. When a member is transferred from an acute care hospital, including a children's or cancer hospital to another acute care hospital, including a children's or cancer hospital, a transfer payment methodology is used. The only exception shall be when the DRG is defined in such a way that it takes into account transfers, such as certain DRGs related to the care of neonates.

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I. Inpatient Hospital Services - Non DRG Payment Methodology

1. Rehabilitation per diem rate

   For dates of service on or after January 1, 2020, the per diem rate for inpatient rehabilitation services provided in a governmental licensed short-term general or children's hospital shall be $1,370.00 and such services provided in a non-governmental licensed short-term general hospital shall be $1,397.40. This per diem rate is inclusive of all hospital service fees and is paid only when the claim is assigned the rehabilitation DRG and the hospital requests and is approved for a per diem prior authorization. The rate of $1,370.00 was calculated based on 80% of the weighted average cost for all hospitals with a rehabilitation distinct part unit reported on their fiscal year 2012 Medicare cost report. The per diem rate for non-governmental licensed short-term general hospitals shall increase 2% each year effective for dates of service on or after January 1, 2021 and each subsequent January 1st through and including January 1, 2026. Each annual increase shall be applied to the rates in effect for the immediately preceding calendar year and the rates in effect as of June 30, 2026 shall remain in effect on or after July 1, 2026 unless modified by a future SPA. Such rates (for non-governmental licensed short-term general hospitals) are detailed in the following table:

2020	2021	2022	2023	2024	2025	2026*
$1,397.40	$1,425.35	$1,453.85	$1,482.93	$1,512.59	$1,542.84	$1,573.70

   * As noted above, the rate in effect as of June 30, 2026 shall remain in effect for discharges on and after July 1, 2026 unless modified by a future SPA.

2. Behavioral Health/Psychiatric per diem rates

   For dates of service on or after January 1, 2020, the per diem rates for inpatient hospital behavioral health/psychiatric services for children and adults are listed in the table below. The per diem rate shall be inclusive of all hospital service fees and is paid only when the claim is assigned a psychiatric DRG and the hospital requests and is approved for a per diem prior authorization.

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a. Payment shall continue as long as placement in this level of care is appropriate.

b. For members under 19 years of age, the department will differentiate between medically necessary acute days and medically necessary discharge delay days. Medically necessary discharge delay days are paid at 85 percent of the applicable tiered rate.

c. Behavioral health/psychiatric per diem rates shall be as follows:

	Medically Necessary Acute Days	Child Medically Necessary Discharge Delay Days
BACKUS	$994.50	$845.33
BRIDGEPORT	$1,071.00	$910.35
BRISTOL	$994.50	$845.33
CCMC	$975.00	$828.75
DANBURY	$994.50	$845.33
DAY KIMBALL	$1,071.00	$910.35
DEMPSEY	$1,125.00	$956.25
GREENWICH	$994.50	$845.33
GRIFFIN	$994.50	$845.33
HARTFORD	$1,071.00	$910.35
HOSP OF CEN. CT	$994.50	$845.33
HUNGERFORD	$1,147.50	$975.38
JOHNSON	$994.50	$845.33
LAWRENCE MEM.	$994.50	$845.33
MANCHESTER	$994.50	$845.33
MIDSTATE	$994.50	$845.33
MIDDLESEX	$1,147.50	$975.38
MILFORD	$994.50	$845.33
NORWALK	$1,147.50	$975.38
ROCKVILLE	$994.50	$845.33
SAINT FRANCIS	$994.50	$845.33
SAINT MARY	$994.50	$845.33
SAINT VINCENT	$994.50	$845.33
SHARON	$994.50	$845.33
STAMFORD	$1,147.50	$975.38
WATERBURY	$994.50	$845.33
WINDHAM	$994.5075	$845.33
YALE-NEW HAVEN	$1,071.00	$910.35

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d. The behavioral health/psychiatric per diem rates for the non-governmental licensed short-term general hospitals listed in subsection f. immediately above shall increase 2% each year effective for dates of service on or after January 1, 2021 and each subsequent January 1st through and including January 1, 2026. Each annual increase shall be applied to the rates in effect for the calendar year immediately preceding calendar year and the rates in effect as of June 30, 2026 shall remain in effect for dates of service on and after July 1, 2026 unless modified by a future SPA.

Such rates (for non-governmental licensed short-term general hospitals) for each applicable per diem category and tier are detailed in the tables below:

Behavioral Health/Psychiatric Per Diem Rates								
Type	2015-2019	2020	2021	2022	2023	2024	2025	2026*
Tier 1	$975.00	$994.50	$1,014.39	$1,034.68	$1,055.37	$1,076.48	$1,098.01	$1,119.97
Tier 2	$1,050.00	$1,071.00	$1,092.42	$1,114.27	$1,136.55	$1,159.28	$1,182.47	$1,206.12
Tier 3	$1,125.00	$1,147.50	$1,170.45	$1,193.86	$1,217.74	$1,242.09	$1,266.93	$1,292.27

Behavioral Health/Psychiatric Discharge Delay Per Diem Rates								
Type	2015-2019	2020	2021	2022	2023	2024	2025	2026*
Tier 1	$828.75	$845.33	$862.23	$879.48	$897.07	$915.01	$933.31	$951.97
Tier 2	$956.25	$910.35	$928.56	$947.13	$966.07	$985.39	1,005.10	$1,025.20
Tier 3	$956.25	$975.38	$994.88	1,014.78	$1,035.08	$1,055.78	$1,076.89	$1,098.43

* As noted above, the rate in effect as of June 30, 2026 shall remain in effect for dates of service on and after July 1, 2026 unless modified by a future SPA.