**DEPARTMENT OF SOCIAL SERVICES**

**Notice of Proposed Medicaid State Plan Amendment (SPA)**

**SPA 19-I: Inpatient Hospital Payments – Annual Adjustment Factor Updates to Account for DRG Grouper Version Changes**

The State of Connecticut Department of Social Services (DSS) proposes to submit the following Medicaid State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS).

## Changes to Medicaid State Plan

Effective on or after April 15, 2019, as described below, SPA 19-I will amend Attachment 4.19-A of the Medicaid State Plan to modify inpatient hospital reimbursement under the All Patient Refined Diagnosis-Related Group (APR-DRG) system.

Specifically, the State Plan will be updated to include an adjustment factor in the 3M APR-DRG reimbursement methodology. The adjustment factor is calculated make overall DRG payment levels under grouper version 36 comparable to the overall payment levels under the prior version, in the aggregate. If necessary to make payment levels comparable, there may be a different adjustment factors for each hospital peer group.

This SPA will also specify that DSS will implement each new grouper version on the January 1st after the version becomes available and will update the applicable adjustment factor(s) every January 1st so that overall payment levels from each DRG grouper version are designed to be comparable to the overall payment levels under the previous version, in the aggregate.

## Fiscal Impact

DSS estimates that this SPA will increase annual aggregate expenditures by approximately $78.4 million in Federal Fiscal Year (FFY) 2019 and $171 million in FFY 2020.

## Obtaining SPA Language and Submitting Comments

This SPA is posted on the DSS web site at this link: http://portal.ct.gov/dss. Scroll down to the bottom of the webpage and click on "Publications" and then click on "Updates." Then click on "Medicaid State Plan Amendments". The proposed SPA may also be obtained at any DSS field office or the Town of Vernon Social Services Department, or upon request from DSS (see below).

To request a copy of the SPA from DSS or to send comments about the SPA, please email: Public.Comment.DSS@ct.gov or write to: Medical Policy Unit, Department of Social Services, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105 (Phone: 860-424-5067). Please reference "SPA 19-I: Inpatient Hospital Payments – Annual Adjustment Factor Updates to Account for DRG Grouper Version Changes".

Anyone may send DSS written comments about the SPA. Written comments must be received by DSS at the above contact information no later than April 11, 2019.

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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 current version of the 3M All Patient Refined Diagnosis Related Grouper (APR-DRG). Each new grouper version will be implemented effective each January 1st after the version becomes available. Payments are 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 the adjustment factor described in number 4 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, an adjustment factor will be incorporated into the DRG base payment calculation described in number 2 above. The adjustment factor is calculated to make the overall payment level under grouper version 36 comparable to the overall payment level under the prior version per peer group. The peer groups and applicable adjustment factors are: 1.128 for children's hospitals, 1.288 for public acute care hospitals, and 1.327 for private acute care hospitals. Effective each January 1st thereafter, the adjustment factors will be updated so that overall payment levels from each new DRG grouper version are calculated to be comparable to the levels for each peer group under the previous version.

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## J. Out-of-State and Border Hospital Reimbursement

1. Standard Payment Methodology. Except as otherwise provided below, each out-of-state and border hospital will be paid as follows and which is also the minimum amount to be paid:

   a. Except as otherwise provided in b. and c. below, in reimbursing for inpatient hospital services to out-of-state and border hospitals, the Department shall pay a DRG base payment of $7,505.68 multiplied by the applicable DRG weight for the discharge plus any applicable outlier payment. Effective April 15, 2019 through December 31, 2019, an adjustment factor of 1.327 will be incorporated into the DRG base payment calculation as described in the DRG payment section of Attachment 4.19-A of the Medicaid State Plan. Effective each January 1st thereafter, the adjustment factor will be updated to the in-state private general acute care hospital factor so that overall payment levels from each new grouper version are comparable to levels under the previous version. 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 in-state 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 Strategy, formerly the Office of Health Care Access, by July 1st will be used in the calculations. If there is no in-state average for a particular organ, the applicable hospital's most recent Medicare cost report will be used to compute actual average acquisition cost.

   b. Out-of-state and border hospitals shall be paid a per diem rate of $1,050.00 for psychiatric discharges.

   c. Out-of-state and border hospitals shall be paid a per diem rate of $1,370.00 for rehabilitation discharges.

2. Hospital Option. Each out-of-state and border hospital may request to have its rate set based on its home state Medicaid base rate excluding add-ons. The adjustment factor in 1.a above may be modified to equalize the impact of different grouper versions.

3. Services Not Available In-State. If the Department determines that a service is not available in Connecticut, the Department may pay an out-of-state or border hospital up to a maximum of the provider's usual and customary charges.