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

JUN 08 2017

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

RE: Connecticut 17-0011

Dear Commissioner Bremby:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 17-0011. This amendment makes legislative revisions to the state's diagnosis-related group (DRG) reimbursement methodology for inpatient services, which was initially implemented in 2015. Specifically, this SPA transitions hospital-specific DRG group base rates to state-wide DRG group base rates by peer groups over a 4 year period in increments of 25% each calendar year. The rates for all peer groups will also be adjusted to incorporate indirect medical education for the applicable hospitals and the original wage index designated by Medicare to account for differences in cost between counties.

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 17-0011 is approved effective January 1, 2017. 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,

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: 17-0011
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, 2017

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 2017 $0
FFY 2018 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A Page 1(i) through 1(iii)
Attachment 4.19A Page, 1-(iii) a (NEW)
Attachment 4.19A Page 1(iv)-(v)

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If applicable)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

10. SUBJECT OF AMENDMENT: Effective January 1, 2017, SPA 17-0011 amends Attachment 4.19-A of the Medicaid State Plan to continue the modernization of the inpatient hospital reimbursement methodology based on Diagnosis Related Groups (DRGs). Specifically, in order to further improve consistency within the reimbursement methodology, this SPA will move from the current hospital-specific DRG base rates to state-wide rates based on peer groups over a four year period, using a methodology that transitions the hospital-specific base rates to the state-wide base rate in increments of 25% each calendar year, as described in the SPA page.

11. GOVERNOR'S REVIEW (Check One):

__ 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:

13. TYPED NAME: Roderick L. Bremby

14. TITLE: Commissioner

15. DATE SUBMITTED: March 31, 2017

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: JUN 08 2017

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 01 2017

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Kristin Fan

22. TITLE: Director, FMCO

23. REMARKS:

FORM HCFA-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 current version of the 3M All Patient Refined Diagnosis Related Grouper (APR-DRG). 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. (See base rate table below.)
3. The DRG relative weights are 3M APR-DRG National Weights.

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B. Dataset

In determining the initial DRG hospital-specific APR-DRG base rate ("base rate") effective January 1, 2015, a nine month dataset was established using paid claims with discharge dates between January 1, 2012 and September 30, 2012 ("base period"), and paid dates through May 3, 2013, extracted from Connecticut's MMIS system ("dataset"). Base rates were calculated utilizing the dataset and the 2012 Medicare and Medicaid cost reports as settled on or before December 31, 2014, so that the hospital-specific base rates would result in the same relative level of reimbursement that the hospital received under the prior inpatient hospital reimbursement system given the same volume and acuity of utilization. Base rate calculations included the following adjustments:

1. The dataset was not trended forward to develop base rates because there were no inflationary increases for inpatient hospital case rates between the base period and December 31, 2014.
2. Capital costs that were previously paid as an add-on to the case rate were incorporated into the calculation of the base rate. To maintain cost neutrality, a statewide trend factor of 17.76% was included in aggregate for the entire period to update capital costs to January 1, 2015.
3. Costs related to behavioral health and rehabilitation services are not included in the base rate.
4. An outlier adjustment factor was developed to target 4.8% of total payments as outlier payments, resulting in an adjustment factor of 0.3375.
5. A coding improvement factor of 4.76% will be tracked as a reserve.
    I. Each hospital had a Base Rate Reduction (BRR) of 4.76% at implementation. A Documentation and Coding Improvement Reserve Recovery Percentage (DCI-RRP) will be determined based on the statewide Case Mix Index (CMI) in 2015 relative to the CMI from the 2012 analytical data set used to develop the payment model. CMI increases are expected to be 4.55% for real increases in acuity, and 5% for DCI-RRP.

    II. Hospitals will be due:
        i. A full refund if the 2015 Statewide CMI is less than or equal to 0.7958 (0.7612 x (1+0.0455)), resulting in a DCI-RRP of 100%.
        ii. A partial refund if the 2015 Statewide CMI is between 0.7958 and 0.8356. A proportionate DCI-RRP will be calculated as: (0.8356-Statewide CMI)/(0.8356 - 0.7958)
        iii. No refund if the 2015 Statewide CMI is greater than or equal to 0.8356 (0.7612 x (1+0.0455) x (1+0.05)), resulting in a DCI-RRP of 0%.

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III. Hospital-Specific Refund Rate (HSRR) will be calculated as BRR of 4.76% x DCI-RRP.

IV. Hospital-Specific DCI Recovery Revenue will be calculated as follows: HSRR x CY2015 hospital-specific number of APR-DRG Discharges x CY 2015 hospital-specific CMI. The recovery revenue generated in this manner restores payment to the hospitals to the extent that the actual DCI varies from the 5% DCI assumption built into the 2015 rates. It serves to recalculate payments for 2015, using the actual DCI results, and actual 2015 cases.

C. Base Rates

Effective for admissions on or after January 1, 2015, base rates shall be:

	Base Rate
BACKUS	$6,217.77
BRIDGEPORT	$9,771.29
BRISTOL	$6,267.28
DANBURY	$8,979.27
DAY KIMBALL	$8,282.19
DEMPSEY	$11,821.63
GREENWICH	$9,549.08
GRIFFIN	$8,072.07
HARTFORD	$6,914.29
HOSP OF CEN. CT	$6,318.97
HUNGERFORD	$5,939.10
JOHNSON	$5,283.08
LAWRENCE MEM.	$7,518.61
MANCHESTER	$8,275.23
MIDSTATE	$7,069.94
MIDDLESEX	$7,428.28
MILFORD	$5,399.06
NORWALK	$10,707.70
ROCKVILLE	$5,294.84
SAINT FRANCIS	$8,036.11
SAINT MARY	$7,168.36
SAINT VINCENT	$6,237.17
SHARON	$8,243.42
STAMFORD	$7,111.24
WATERBURY	$7,272.06
WINDHAM	$7,549.23
YALE-NEW HAVEN	$7,246.40
CCMC	$11,344.86

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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: privately operated acute care hospitals, publicly operated acute care hospitals, and acute care children's hospitals licensed by the Department of Public Health.

Phase-in of the base rates for the privately operated acute care 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. Adjustments will be applied to 69.6% of the base rate, the labor portion.

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.

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

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 (above the DRG payment plus the calculated threshold) 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.

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; 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.