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

MAY 18 2015

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

RE: Connecticut 15-003

Dear Mr. Bremby:

We have reviewed the proposed amendment to Attachments 3.1-A, 3.1-B, and 4.19-A, of your Medicaid State plan submitted under transmittal number (TN) 15-003. This amendment implements the All Patient Refined-Diagnosis Related Group (ARP-DRG) reimbursement system using national weights and hospital specific base rates.

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 15-003 is approved effective January 1, 2015. 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,

Timothy Hill
Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 15-003
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
01/01/2015

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
42 CFR 440.10 and 42 CFR 447.253(a)(b)and(c)

7. FEDERAL BUDGET IMPACT:
a. FFY 2015 $0
b. FFY 2016 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A, pages 1a&1b, 3.1-B, pages 1a&1b, and 4.19-A, pages 1(i)-(xi), 3, 4 & 32

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If applicable)
Attachment 3.1-A, pages 1a&1b, 3.1-B, pages 1a&1b, and 4.19-A, pages 1(i)-(viii), 3, 4 & 32

10. SUBJECT OF AMENDMENT:
This SPA amends attachments 3.1-A, 3.1-B, and 4.19-A to reflect a new inpatient reimbursement methodology effective for admissions on or after January 1, 2015. Medicaid rates paid to acute care and children's hospitals will be based on diagnosis-related groups established and periodically rebased. Specifically, claims will be paid using the 3M All Patient Refined – Diagnosis Related Group (APR-DRG) system using national weights and hospital-specific base rates for in-state hospitals and the in-state weighted average base rate for out-of-state hospitals including border hospitals. Exceptions to the DRG methodology will be reimbursed on a per diem basis as described in the State Plan. This change is budget-neutral and is necessary to modernize the Connecticut Medicaid program's reimbursement methodology for inpatient hospital services and to align more closely with Medicare and other payers.

11. GOVERNOR'S REVIEW (Check One):

__X__GOVERNOR'S OFFICE REPORTED NO COMMENT
__COMMENTS OF GOVERNOR'S OFFICE ENCL
__NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
__OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

TYPED NAME: Roderick L. Bremby

14. TITLE: Commissioner

15. DATE SUBMITTED:
February 19, 2015

16. RETURN TO:

State of Connecticut
Department of Social Services
55 Farmington Avenue
Hartford, CT 06105

Attention: Ginny Mahoney, Medical Policy

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: MAY 18 2015

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JAN 01 2015

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Kristin Fan

22. TITLE: Deputy Director, FMC

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

Effective for admissions on or after January 1, 2015, 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 All Patient Refined Diagnosis Related Grouper (APR-DRG) version 31. 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 version 31 National Weights.

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

B. Dataset

In determining the first year DRG hospital-specific APR-DRG base rate ("base rate"), 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. For the interim period of calendar year 2015, 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. Interim payments to providers will be the base rates listed under section (1)c. At the end of calendar year 2015, the state will reconcile the interim DRG payments to final DRG rates based on the actual statewide CMI as defined below.

    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%.

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

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

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.

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.

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.

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

I. Inpatient Hospital Services - Non DRG Payment Methodology

1. Rehabilitation per diem rate

   The per diem rate for inpatient rehabilitation services provided in an acute care hospital shall be $1,370.00. 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 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.

2. Psychiatric per diem rates

   The per diem rates for inpatient hospital 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.

   a. Hospitals without a distinct part unit (DPU) are paid the tier one rate of $975.00.

   b. For hospitals with psychiatric DPUs, each hospital is assigned a psychiatric per diem rate that will most closely match historical revenue levels for psychiatric inpatient days.

   c. For hospitals with psychiatric DPUs, psychiatric per diem rate assignment will also take into consideration psychiatric inpatient costs as reported in the hospital's fiscal year 2012 Medicare cost report. If a hospital would lose revenue under the rate assigned under step b. (above), and the assigned rate would not provide 100% of costs, then the hospital will be assigned the rate one tier higher than what it would otherwise be assigned, unless it is already assigned to the highest tier.

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

   e. 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.

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

f. Psychiatric per diem rates shall be as follows:

	Medically Necessary Acute Days	Child Medically Necessary Discharge Delay Days
BACKUS	$975.00	$828.75
BRIDGEPORT	$1,050.00	$892.50
BRISTOL	$975.00	$828.75
CCMC	$975.00	$828.75
DANBURY	$975.00	$828.75
DAY KIMBALL	$1,050.00	$892.50
DEMPSEY	$1,125.00	$956.25
GREENWICH	$975.00	$828.75
GRIFFIN	$975.00	$828.75
HARTFORD	$1,050.00	$892.50
HOSP OF CEN. CT	$975.00	$828.75
HUNGERFORD	$1,125.00	$956.25
JOHNSON	$975.00	$828.75
LAWRENCE MEM.	$975.00	$828.75
MANCHESTER	$975.00	$828.75
MIDSTATE	$975.00	$828.75
MIDDLESEX	$1,125.00	$956.25
MILFORD	$975.00	$828.75
NORWALK	$1,125.00	$956.25
ROCKVILLE	$975.00	$828.75
SAINT FRANCIS	$975.00	$828.75
SAINT MARY	$975.00	$828.75
SAINT VINCENT	$975.00	$828.75
SHARON	$975.00	$828.75
STAMFORD	$1,125.00	$956.25
WATERBURY	$975.00	$828.75
WINDHAM	$975.00	$828.75
YALE-NEW HAVEN	$1,050.00	$892.50

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

3. Child and Adolescent Rapid Emergency Stabilization Services (CARES) per diem rate

Effective January 1, 2015, the per diem rate for intermediate Child and Adolescent Rapid Emergency Stabilization Services (CARES) provided in a designated general hospital unit with an approved Certificate of Need that specifically provides for the operation of a CARES unit for such services shall be:

Days 1-3: $1,152.34 per diem

Such per diem rates are inclusive of all hospital service fees. Payment shall be limited to 3 days, except that for those children authorized by the Department for admission to the Connecticut state operated psychiatric residential treatment facility or to a specialized out-of-state residential or hospital facility, payment shall be permitted beyond the 3-day limit at $1,152.34 per day. The Department may otherwise authorize payment beyond the 3-day limit on an exception basis.

4. Intermediate duration acute psychiatric care for adults per diem rates

Effective January 1, 2015, per diem rates for intermediate duration acute psychiatric care provided in a designated general hospital unit certified by the state Department of Mental Health and Addiction Services for such services shall be:

Days 1-29: $877.34
Days 30+: $802.34

Such per diem rates are inclusive of all hospital service fees. Payment shall continue as long as placement in this level of care is appropriate. Inpatient stays that include transfer to intermediate duration acute psychiatric care beds from other inpatient psychiatric beds within a hospital shall be paid based on the intermediate duration psychiatric care rate schedule for all days.

5. Connecticut Hospice

Effective January 1, 2015, the per diem rate for inpatient services provided by Connecticut Hospice shall be $650.00. The per diem rate is inclusive of all hospital service fees and hospital-based professional services.

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

J. Out-of-State and Border Hospital Reimbursement

1. In reimbursing for inpatient hospital services to out-of-state and border hospitals, the department shall pay the statewide average DRG base payment of $7,855.63 multiplied by the applicable DRG weight for the discharge plus any applicable outlier payment.
2. Out-of-state and border hospitals shall be paid the statewide average per diem rate of $1,050.00 for psychiatric discharges.
3. Out-of-state and border hospitals shall be paid the statewide per diem rate of $1,370.00 for rehabilitation discharges.
4. Each out-of-state and border hospital may have its rate set based on its home state Medicaid rate, its Medicare base rate, or its percentage of allowable costs to charges based on its most recent Medicare cost report. Such percentage is applied to usual and customary charges in determining reimbursement.

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

(2) **Supplemental Reimbursement for Inpatient Hospital Services.**
Supplemental payments to eligible hospitals shall be made from a pool of funds in the amount of $229.8 million for the year ending June 30, 2014 and $95.6 million for the year ending June 30, 2015. The payments shall be made periodically throughout each fiscal year. The payments are comprised of two pools:

A pool of $214.7 million for the year ending June 30, 2014 and a pool of $80.5 million for the year ending June 30, 2015:

(a) Hospitals eligible for supplemental payments under this paragraph are short-term general hospitals other than short-term children's general hospitals and short-term acute care hospitals operated exclusively by the State, other than a short-term acute care hospital operated by the State as a receiver.

(b) Each eligible hospital's share of the supplemental payment pool shall be equal to that hospital's pro rata share of the total Medicaid inpatient revenues of all eligible hospitals in the aggregate. For purposes of this supplemental payment, "Medicaid inpatient revenues" means payments for Medicaid inpatient hospital services provided in federal fiscal year 2010 to each eligible hospital up to $25 million per year per hospital as reported in each hospital's filing with the State of Connecticut Office of Health Care Access (OHCA).

A pool of $15.1 million per year for the years ending June 30, 2014 and June 30, 2015:

Qualifying hospitals are those described in the pool above that also meet all of the following criteria: (1) Medicaid case rate lower than the weighted average, (2) expense per case mix adjusted equivalent discharge lower than the weighted average, and (3) combined Medicare and Medicaid payer mix higher than the weighted average. Criteria are based on the current case rates and each hospital's most recent finalized filing with OHCA and qualifiers shall be redetermined annually. The minimum annual payment to a qualified hospital shall be $100,000.

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

(4) Disproportionate Share Payment Adjustment

This section will define the criteria for deeming hospital's eligible for the disproportionate share payment adjustment effective through December 31, 2014, and will further define the payment adjustment to be made to the hospitals that qualify.

A. Minimum Requirement

1. In order to qualify as a disproportionate share hospital the criteria stated and defined in Sections 1923(b)(1), 1923(b)(2) or 1923(b)(3) of the Social Security Act must be met; and

2. The hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures.

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

3. Subsection A.2. does not apply to a hospital which:

- Does not offer non-emergency obstetric services as of 12/21/87.

B. Once a hospital is deemed to be eligible for a disproportionate share payment adjustment, additional payment will be calculated by multiplying the hospital's maximum cost per discharge amount by the hospital's Medicare disproportionate share adjustment percentage developed under the rules established under Section 1886 (d) (5) (F) (iv) of the Act that can be paid to eligible hospitals.

The DSS will test the calculated disproportionate share payments allocated to each hospital in each year to ensure that 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.

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

Payment Adjustment for Provider Preventable Conditions

Citation 42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903
The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A) of this State plan.

__X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section 4.19 (A) of this State plan.

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

____ Additional Other Provider-Preventable Conditions identified below: None

Payment Adjustment

For claims reimbursed using Diagnosis Related Groups (DRG), the DRG assignment will be determined with and without the hospital acquired condition. Reimbursement will be calculated using the lower weighted DRG.

For claims reimbursed under a per diem methodology, to the extent that the cost of the hospital acquired condition can be isolated, payment for the cost of the hospital acquired condition will be denied.

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

Assurances

1. No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

2. Reductions in provider payment may be limited to the extent that the following apply: (i) The identified provider preventable conditions would otherwise result in an increase in payment; (ii) The State can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the provider preventable condition.

3. A State plan must ensure that nonpayment for provider-preventable conditions does not prevent access to services for Medicaid beneficiaries.

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

(4) Private Psychiatric Hospitals for individuals under 22 and over 64 years of age:

a. Effective July 1, 2011, the per diem rate for acute psychiatric care provided in a private psychiatric hospital shall be $814.65.

Effective January 1, 2012, per diem rates for private psychiatric hospitals will differentiate between adults 19 years of age and older and children 18 years of age and younger. Additionally, the adult psychiatric per diem rates will differentiate between lengths of stays less than 30 days and stays of 30 days or more. Additionally, the child psychiatric per diem rates will differentiate between medically necessary acute days and medically necessary discharge delay days.

Effective January 1, 2012, per diem rates for private psychiatric hospitals shall be:

	Adult Per Diem		Child Per Diem	
	Days 1-29	Days 30+	Acute Days	Discharge Delay Days
NATCHAUG	$814.65	$692.45	$829.96	$705.47

b. The per diem rate is inclusive of all hospital service fees and hospital-based professional services. Payment shall continue as long as placement in this level of care is appropriate.

c. Each out-of-state psychiatric hospital may have its rate set optionally based on the statewide average of $1,050.00 per day paid to general acute care hospitals for behavioral health services, its home state Medicaid rate, its Medicare base rate, its percentage of allowable costs to charges based on its most recent Medicare cost report, or 42.9% of charges. Such percentage is applied to usual and customary charges in determining reimbursement.

State: CONNECTICUT

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
CATEGORICALLY NEEDY GROUP(S): ALL

1. Inpatient Hospital Services -

a. The following inpatient hospital services are covered only in accordance with the following limitations:

1. An inpatient stay related to surgical services medically necessary to treat morbid obesity only when another medical illness is caused by, or is aggravated by, the obesity, including illnesses of the endocrine system or the cardio-pulmonary system, or physical trauma associated with the orthopedic system;

2. In connection with organ transplant surgery, the following inpatient hospital services provided to the organ donor are also covered: harvesting; diagnostic testing; medications; transportation services; and any service related to the actual procedure.

b. The following inpatient hospital services are not covered:

1. Any services that are unproven or experimental or any services that are solely for cosmetic, research, or social purposes;

2. Any services or items furnished for which the provider does not usually charge;

3. For any services not reimbursed pursuant to the Diagnosis Related Group (DRG) methodology described in Attachment 4.19-A of the State Plan, the following services are not covered:

A. Except for one-day inpatient hospital stays, the day of discharge or transfer;

B. Any day when the beneficiary is out of the hospital at the time of the census count (12:00 Midnight), including, but not limited to, absences due to a Leave of Absence (LOA), Pass with Medical Permission, or a Pass without Medical Permission;

4. Emergency department or observation services provided on the same day at the same hospital as the inpatient admission;

5. Infertility treatment and sterilization reversal;

State: CONNECTICUT

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
CATEGORICALLY NEEDY GROUP(S): ALL

6. Admissions and day(s) of care that do not meet established requirements for medically necessary acute care inpatient hospital service. Payment will be denied for acute care inpatient hospital services if the Department determines that the medical care, treatment or service does not or did not meet the established medically necessary and/or utilization review standard in accordance with generally accepted criteria and standards of medical practice, or if they do not or did not comply with the other policies, procedures, conditions and limitations established by the Department. This determination may be made at the time of prior authorization, preadmission review, concurrent review, or retrospective review. The fact that a denial was not made at an earlier stage shall not preclude such a determination at a later stage. The Department is entitled to disallow the entirety or any portion of the stay and services provided they do not meet the medically necessary or utilization review standard.

7. Approved inpatient hospital rates shall be reduced or eliminated for admissions during which a hospital acquired condition occurs. For the purposes of this section, hospital-acquired condition means those conditions identified as non-payable by Medicare pursuant to Section 5001 (c) of the Deficit reduction Act of 2005.

8. Inpatient hospital services that can be performed in an outpatient setting, such as fetal monitoring or false labor.

State: CONNECTICUT

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

1. Inpatient Hospital Services -

a. The following inpatient hospital services are covered only in accordance with the following limitations:

1. An inpatient stay related to surgical services medically necessary to treat morbid obesity only when another medical illness is caused by, or is aggravated by, the obesity, including illnesses of the endocrine system or the cardio-pulmonary system, or physical trauma associated with the orthopedic system;

2. In connection with organ transplant surgery, the following inpatient hospital services provided to the organ donor are also covered: harvesting; diagnostic testing; medications; transportation services; and any service related to the actual procedure.

b. The following inpatient hospital services are not covered:

1. Any services that are unproven or experimental or any services that are solely for cosmetic, research, or social purposes;

2. Any services or items furnished for which the provider does not usually charge;

3. For any services not reimbursed pursuant to the Diagnosis Related Group (DRG) methodology described in Attachment 4.19-A of the State Plan, the following services are not covered:

A. Except for one-day inpatient hospital stays, the day of discharge or transfer;

B. Any day when the beneficiary is out of the hospital at the time of the census count (12:00 Midnight), including, but not limited to, absences due to a Leave of Absence (LOA), Pass with Medical Permission, or a Pass without Medical Permission;

4. Emergency department or observation services provided on the same day at the same hospital as the inpatient admission;

5. Infertility treatment and sterilization reversal;

State: CONNECTICUT

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

6. Admissions and day(s) of care that do not meet established requirements for medically necessary acute care inpatient hospital service. Payment will be denied for acute care inpatient hospital services if the Department determines that the medical care, treatment or service does not or did not meet the established medically necessary and/or utilization review standard in accordance with generally accepted criteria and standards of medical practice, or if they do not or did not comply with the other policies, procedures, conditions and limitations established by the Department. This determination may be made at the time of prior authorization, preadmission review, concurrent review, or retrospective review. The fact that a denial was not made at an earlier stage shall not preclude such a determination at a later stage. The Department is entitled to disallow the entirety or any portion of the stay and services provided they do not meet the medically necessary or utilization review standard.

7. Approved inpatient hospital rates shall be reduced or eliminated for admissions during which a hospital acquired condition occurs. For the purposes of this section, hospital-acquired condition means those conditions identified as non-payable by Medicare pursuant to Section 5001 (c) of the Deficit reduction Act of 2005.

8. Inpatient hospital services that can be performed in an outpatient setting, such as fetal monitoring or false labor.