DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 21-F: Inpatient Hospital Reimbursement

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 for inpatient hospital discharges on or after January 1, 2021, SPA 21-F will amend Attachment 4.19-A of the Medicaid State Plan to clarify which version of diagnosis-related group (DRG) relative weights will be used as part of the methodology for determining the payment for inpatient hospital services paid under the DRG methodology. The purpose of this SPA is to clarify the state plan language to reflect additional detail regarding the applicable version of DRG relative weights to account for recent changes in the available weight versions within the All-Patient Refined (APR) DRG National Weights established by 3M, which DSS uses in the DRG payment methodology.

Fiscal Impact

DSS anticipates that this SPA will not change annual aggregate expenditures because this SPA clarifies the existing approved Medicaid State Plan and will not change the overall fiscal impact.

Obtaining SPA Language and Submitting Comments

The proposed SPA is posted on the DSS website 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, at 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: Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105 (Phone: 860-424-5067). Please reference "SPA 21-F: Inpatient Hospital Reimbursement Clarification".

Anyone may send DSS written comments about the SPA. Written comments must be received by DSS at the above contact information no later than December 24, 2020.

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 using the national version that minimizes the estimated financial impact on payments by hospital compared to the prior year.