DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 18-0001: Inpatient Hospital Payments – Rate Increase and Mid-Sized Hospital Supplemental Payments

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 January 1, 2018, as described below, SPA 18-0001 will amend Attachment 4.19-A of the Medicaid State Plan in accordance with section 17b-239e of the Connecticut General Statutes, as amended by section 618 of Public Act 17-2 of the June special session and as further amended by section 11 of 2017 Senate Bill 1503 and also in accordance with subsection (i) of section 17b-239 of the Connecticut General Statutes, as amended by section 619 of Public Act 17-2 of the June special session and as further amended by section 12 of 2017 Senate Bill 1503. This SPA implements a Medicaid inpatient hospital rate increase and supplemental payments to specified mid-sized hospitals.

Specifically, the diagnosis-related group (DRG) base rate for privately operated general acute care hospitals will increase by 31.65%, which is estimated to increase aggregate rate payments by approximately $58 million for state fiscal year (SFY) 2018 and $140 million for SFY 2019. Mid-sized hospital supplemental payments will total $65 million each year for SFYs 2018 and 2019. Qualifying hospitals are acute care general hospitals that, as reported in each hospital's Federal Fiscal Year (FFY) 2016 filing with the Department of Public Health, Office of Health Care Access (OHCA), have: (1) staffed beds of not less than 150 but not more than 300 and (2) Medicaid gross revenue of not less than 6% but not more than 18% of total revenue. Payments will be calculated using each hospital's pro rata share of Medicaid inpatient revenue, subject to a cap of $14.5 million, of all eligible hospitals in the aggregate as reported in each hospital's FFY 2016 filing with OHCA.

Fiscal Impact

DSS estimates that this SPA will increase annual aggregate expenditures by approximately $123.3 million in SFY 2018 and $205.0 million in SFY 2019.

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 18-0001: Inpatient Hospital Payments – Rate Increase and Mid-Sized Hospital Supplemental Payments".

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 28, 2017.

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.

4. Effective for admissions on or after January 1, 2018, the base rates for privately operated acute care hospitals shall increase by 31.65%.

(2b) Supplemental Reimbursement to Mid-Sized Hospitals for Inpatient Hospital Services.

Supplemental payments to eligible hospitals shall be made from a pool of funds in the amount of $65 million for each of the state fiscal years ending June 30, 2018 and June 30, 2019. The payments shall be made periodically throughout each fiscal year in accordance with the following paragraphs:

(a) Hospitals eligible for supplemental payments under this section are privately operated short-term general acute care hospitals that, as reported in each hospital's Federal Fiscal Year 2016 filing with the Department of Public Health, Office of Health Care Access (OHCA), have: (1) staffed beds of not less than 150 but not more than 300 and (2) Medicaid gross revenue of not less than 6% but not more than 18% of total revenue.

(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, subject to a cap of $14.5 million, of all eligible hospitals in the aggregate as reported in each hospital's Federal Fiscal Year 2016 filing with OHCA.