DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 19-Y: Outpatient 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

Based on the Governor's proposed budget and the most recent versions of the draft state budget and implementing legislation for State Fiscal Years (SFY) 2020 and 2021 and actions to date by the General Assembly, including the Appropriations Committee version of the draft state budget and the current version of House Bill 7164, it is anticipated that SPA 19-Y will amend Attachment 4.19-B of the Medicaid State Plan effective on or after July 1, 2019 to make the following changes to outpatient hospital reimbursement.

(1) Implement one or more pools of outpatient supplemental payments to specified acute care hospitals.

(2) Implement one or more value-based payment methodologies in order to improve health outcomes and reduce unnecessary costs.

(3) For each outpatient hospital observation stay that is defined as a readmission, reduce outpatient hospital rate payments by 15% for each such observation stay and related outpatient hospital services. An observation stay is defined as a readmission if it occurs within 30 days of an inpatient hospital discharge for the same or similar diagnosis as the observation stay.

Although budget proposals and implementing legislation are still pending in the General Assembly at the time this notice is being prepared and this proposal may be modified in whole or in part before adoption of the final state budget for SFY 2020 and 2021, federal regulations require DSS to submit public notice at this time. Accordingly, this SPA is subject to change, in whole or in part, as necessary to comply with the final approved state budget and implementing legislation for SFY 2020 and 2021.

Fiscal Impact

Based on preliminary estimates using the information that is available at this time, DSS estimates that this SPA will change annual aggregate expenditures compared to the levels currently specified in the Medicaid State Plan for SFY 2020 and 2021 as follows:

(1) Increase annual aggregate expenditures in an approximate range of between $20.0 million and $57.8 million for supplemental payments in SFY 2020 and between $16.0 million and $53.8 million

for SFY 2021. Because the effective date of the current Medicaid State Plan language regarding outpatient hospital supplemental payments ends as of June 30, 2019, any supplemental payment amounts in SFY 2020 and 2021 reflect an increase compared to the current language.
(2) Increase of $2.0 million in SFY 2020 and $5.9 million in SFY 2021, to be allocated for value-based supplemental payments.

(3) Decrease of approximately $1 million in SFY 2020 and $1 million in SFY 2021 for reduction in payment for observation stays that are defined as readmissions, as described above.

Compliance with Federal Access Regulations

As described above, this SPA proposes to change outpatient hospital reimbursement in various ways, including a proposal to reduce payment by 15% for observation stays that are defined as readmissions, as described above. In accordance with federal regulations at 42 C.F.R. §§ 447.203 and 447.204, DSS is required to ensure that there is sufficient access to Medicaid services, including services where payment rates are proposed to be reduced or where payment rates or methodologies are being restructured in a manner that may affect access to services. Those federal regulations also require DSS to have ongoing mechanisms for Medicaid members, providers, other stakeholders, and the public to provide DSS with feedback about access. In addition to other available procedures, anyone may send DSS comments about the potential impact of this SPA on access to outpatient hospital services as part of the public comment process for this SPA. Contact information and the deadline for submitting public comments are listed below.

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-Y: Outpatient Hospital Reimbursement".

Anyone may send DSS written comments about the SPA. Written comments must be received by DSS at the above contact information no later than June 28, 2019.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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Payment Rate and Limitations for Hospitals Reimbursed Using APCs

The CMAP APC system is based on Medicare's Addendum B (OPPS payment by HCPCS code as modified and reflected in CMAP Addendum B), Addendum A (list of APCs) and Addendum D1 (list of payment status indicators) and uses Medicare's APC grouper software. Effective July 1, 2016, APC IOCE Version 17.1 will be used. When Medicare issues subsequent APC IOCE versions, the CMAP APC system will adopt such version with the same effective date as Medicare. In order to implement each such new version, the department will update Addendum B in accordance with such version and in conformance with the existing methodology and policy as reflected in the current version of CMAP Addendum B, including any new or deleted codes that were included by Medicare.

CMAP Addendum B also includes a column entitled "Payment Type" that indicates whether an item is reimbursable based on the APC methodology, the applicable fee schedule or other prospective payment methodology.

1. Effective for services provided on or after July 1, 2016, for applicable services as specified in CMAP Addendum B, the department pays for outpatient hospital services on a fully prospective per service basis using an APC payment methodology in accordance with this section.
2. Effective for services provided on or after July 1, 2016, the statewide conversion factor established by the department is $82.25 for acute care general children's hospitals and $71.76 for acute care general hospitals, private chronic disease hospitals, and private psychiatric hospitals. Effective for services provided on or after January 1, 2018, the statewide conversion factor established by the department for acute care general hospitals is $76.42.
3. The conversion factor is adjusted for the hospital's wage index based on the original Medicare assignment. Medicare reclassifications of the geographic wage index will not be recognized. The wage index is updated annually effective January 1st of each year. The wage index is applied to the labor-related share percentage of the conversion factor established by Medicare and is updated annually effective January 1st of each year.
4. Hospitals located outside of Connecticut shall be paid the statewide conversion factor of $71.76, with no adjustment for the wage index for services reimbursed using APCs, except that if a hospital requests to have the conversion factor adjusted for the hospital's actual wage index, the department may grant such request on a case-by-case basis if the department determines that such adjustment is necessary to ensure access to medically necessary services for a beneficiary. For services reimbursed using a non-APC methodology, hospitals located outside of Connecticut shall be reimbursed in the same manner as hospitals located in Connecticut. However, if the department determines that a service is not available in Connecticut, the department may negotiate payment rates and conditions with such provider, up to, but not exceeding, the provider's usual and customary charges.
5. Observation Services. Observation services shall include not less than eight hours but not greater than forty-eight hours of continuous care. Observation services are reimbursed using APCs. The hospital may bill for ancillary services related to observation only if such services are ordered during the observation stay. Effective for dates of service on

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or after July 1, 2019, for each observation stay that is defined as a readmission, the outpatient hospital rate payment shall be reduced by 15% for each such observation stay and related outpatient hospital services. An observation stay is defined as a readmission if it occurs within 30 days of an inpatient hospital discharge for the same or similar diagnosis as the observation stay.

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Supplemental Reimbursement to Privately Owned or Operated Acute Care General Hospitals for Providing Outpatient Hospital Services

Supplemental payments to eligible hospitals shall be made from a pool of funds in the amount of $57.8million for the state fiscal year ending June 30, 2020 and $53.8 million for the state fiscal year ending June 30, 2021. 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 short-term acute care general hospitals other than short-term children's general hospitals and short-term acute care general hospitals operated exclusively by the State, other than a short-term acute care general 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 outpatient revenues of all eligible hospitals in the aggregate as reported in each hospital's Federal Fiscal Year 2016 filing with the State of Connecticut, Office of Health Strategy (OHS), formerly Department of Public Health, Office of Health Care Access (OHCA).

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Supplemental Reimbursement for Value-Based Payment Methodologies for Outpatient Hospital Services.

Value-based supplemental payments shall be made to eligible hospitals from a pool of funds of up to $2.0 million for the state fiscal year ending June 30, 2020 and up to $5.9 million for the state fiscal year ending June 30, 2021.