DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)
SPA 20-0002: 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 anticipated adoption of state legislation in an upcoming special session, SPA 20-0002 will amend Attachment 4.19-B of the Medicaid State Plan effective for dates of service on or after January 1, 2020 to change outpatient hospital reimbursement as follows: (1) one or more outpatient hospital rates will be increased by a specified percentage for one or more years and (2) the methodology for using wage index values in setting outpatient hospital payments will be modified.

Although the implementing legislation has not yet been adopted by the General Assembly, 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 enacted legislation from the special session.

Fiscal Impact

DSS estimates that this SPA will increase annual aggregate expenditures for State Fiscal Year (SFY) 2020 and SFY 2021 with the value of the increases in expenditures dependent on the extent of the rate increases and wage index methodology changes to be provided.

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 20-0002: 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 December 27, 2019.

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

Overall Payment Methodology

1. Outpatient hospital services are provided pursuant to 42 CFR 440.20(a).
2. No inflation, inflationary factor, or any other automatic increase is included in any reimbursement for outpatient hospital services except for increases noted below beginning with dates of service on or after January 1, 2020. Reimbursement is solely based upon the methodology described below.
3. Reimbursement for outpatient hospital services and other services prior to inpatient hospital admission.
   a. Except as provided in subdivision b. of this subsection, reimbursement for inpatient hospital services includes payment for all outpatient hospital services provided by the hospital or another hospital that is an affiliated hospital at any location, including the hospital's main campus and any satellite location, on the date of admission and the two days prior to the date of admission, which shall not be separately reimbursed by the department and shall be billed as part of the inpatient hospital stay.
   b. The department pays a hospital or an affiliated hospital separately for the following services provided on the date of admission but before the actual admission and the two days prior to the date of admission: Any service clinically unrelated to the admission, maintenance renal dialysis, physical therapy, occupational therapy, speech and language pathology services, audiology services, routine psychotherapy, electroconvulsive therapy (except if the electroconvulsive therapy causes the admission), psychological testing, neuropsychological testing, intermediate care programs and any other category of service specifically designated on the outpatient hospital fee schedule referenced below.

4. The department shall pay hospitals for providing outpatient hospital services using CMAP OPPS. As determined and designated by the department, services are paid using one or more of the following methodologies and in accordance with the department's fee schedules and payment rules as defined in CMAP Addendum B, which is posted to www.ctdssmap.com:
   a. APC payment based on Medicare's system as modified for CMAP, as detailed below;
   b. A fee on the department's fee schedule for outpatient hospitals, which has been updated as of January 1, 2020, and is posted to www.ctdssmap.com;

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Overall Payment Methodology (continued)

c. A fee on one of the department's fee schedules other than the outpatient hospital fee schedule. For each service that is paid using a fee schedule, CMAP Addendum B specifies the applicable fee schedule, which is updated as of the effective date listed in the applicable section of Attachment 4.19-B and is also posted to www.ctdssmap.com; or

d. Other prospective payment as included in CMAP Addendum B.

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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. Effective for services provided on or after January 1, 2020, one or more conversion factors shall be increased by a specified percentage for one or more years after anticipated legislation providing for such changes is approved in special session.
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 except as otherwise provided in this paragraph. Effective for dates of service on or after January 1, 2020,

the methodology for using wage index values will be modified after anticipated legislation providing for such changes is approved in special session.

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.