

DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

Hospital Reimbursement for Long Acting Reversible Contraceptive (SPA 16-016)

The State of Connecticut Department of Social Services (DSS) proposes to submit the following amendment to the Medicaid State Plan 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 April 15, 2016, SPA 16-016 will amend attachment 4.19-A to reimburse hospitals for Long Acting Reversible Contraceptive (LARC) separately from the inpatient All Patient Refined Diagnosis Related Group (APR-DRG) payment only when the LARC is provided as part of the inpatient obstetrical delivery. This change is intended to expand access to contraceptive supplies and services under the Medicaid program, as well as a proposed cost savings measure.

Fiscal Information

Based on current information, DSS estimates that this SPA will increase annual aggregate expenditures by approximately \$36,000 in Federal Fiscal Year 2016 and \$94,000 in Federal Fiscal Year 2017. However, when considering the likely impact of this change on reducing expenditures associated with fewer unwanted pregnancies, overall expenditures are projected to be reduced.

Information on Obtaining SPA Language and Submission of Comments

In accordance with federal Medicaid requirements, upon request, DSS will provide copies of the proposed SPA. Copies of the proposed SPA may also be obtained at any DSS regional office and on the DSS website: <http://www.ct.gov/dss>. Go to “Publications” and then “Updates”.

Written, phone, and email requests should be sent to Ginny Mahoney, Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105 (Phone: 860-424-5145, Fax: 860-424-5799, Email: ginny.mahoney@ct.gov). Please reference “SPA 16-016: Hospital Reimbursement for Long Acting Reversible Contraceptive”. Members of the public may also send DSS written comments about this SPA. Written comments must be received by DSS at the above contact information no later than April 14, 2016.

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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 July 1st 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 July 1st will be used in the calculations.
3. Long Acting Reversible Contraceptive (LARCs) will be reimbursed separately from the APR-DRG payment. A separate outpatient claim may be submitted by the hospital for reimbursement under Revenue Center Code 253 in conjunction with the following codes: J7297, J7298, J7300, J7301 and J7307. Reimbursement for these codes will be based on the CMS approved outpatient hospital reimbursement methodology as described in 4.19-B page 1.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES—OTHER TYPES OF CARE

(2) (a) Outpatient hospital services – The agency reimburses outpatient hospital services using both fixed fees and cost to charge ratios. The agency’s fixed fees were set as of April 15, 2016 and are effective for services on or after that date. Fixed fees are published on the Department’s website at www.ctdssmap.com. Fixed fees are paid for various categories of outpatient hospital services, including, but not limited to: diagnostic laboratory services, imaging, therapies, group tobacco cessation counseling, behavioral health, and various other categories of service according to the revenue center codes listed in the fee schedule. For revenue center codes not listed on the fee schedule, the rate for each code is based on the hospital-specific cost to charge ratio for each applicable ancillary or outpatient department as designated by the hospital and reported on the hospital’s fiscal year 2012 cost report filing, as determined by the Department. The rate schedule is sent to each hospital and is revised annually (July 1) based on the most recently filed cost report. Rates for outpatient hospital services are not reconciled to actual costs.

There are higher fees for outpatient hospital behavioral health services that meet special access and quality standards as enhanced care clinics (ECCs), as noted on the hospital-specific schedule for each hospital that has an ECC. ECCs must accept all (100%) telephonic and walk-in referrals that present during business hours. All referrals must be screened by a trained intake worker or clinician and triaged to determine whether the referral is emergent, urgent or routine. A clinician must evaluate a client who presents at the clinic with an emergent condition within two (2) hours. Clients that undergo telephonic or walk-in screening and are determined to be in urgent need of services must be offered an appointment for an urgent face-to-face clinical evaluation with a clinician to take place within two (2) calendar days of the screening. Clients that undergo telephonic or walk-in screening and are determined to have routine needs must be offered an appointment for a routine face-to-face clinical evaluation with a clinician to take place within 14 calendar days of the screening. ECCs must have at least nine (9) extended hours per week beyond routine business hours of 8:00 AM to 5:00 PM. ECCs have a valid Letter of Agreement with the Department that holds them accountable to the quality standards and access standards receive the enhanced rate for all routine outpatient services provided. The state monitors the access standards on a routine basis and provides access standard reports to the providers on a quarterly basis. The state has established a process for providers to submit corrective action plans (CAPs) if they do not meet the access standards for any reason except in increase in volume in excess of 20% compared to the same quarter of the previous year. ECCs must electronically register appointments made with the Administrative Services Organization (ASO). This process allows for an automated process to track access standards for routine cases. The state also utilizes a mystery shopper process to track access standards. The state also does on-site chart reviews to determine if providers are in compliance with quality standards and the urgent and emergent access standards. As a result of the on-site reviews, CAPs will be required from providers who do not meet quality or access standards reviewed. Fees for services provided to individuals 18 years of age and over are 95% of the published fee for ECCs.

Except as otherwise noted in the plan, state developed fee schedules and rate methods are the same for both governmental and private providers.

TN # 16-016
 Supersedes
 TN # 15-018

Approval Date _____

Effective Date 04/15/2016