

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, M/S S3-13-15  
Baltimore, MD 21244-1850



DEC 20 2013

RECEIVED  
State of Connecticut

Roderick L. Bremby, Commissioner  
Department of Social Services  
25 Sigourney Street  
Hartford, CT 06106-5033

DEC 23 2013

Dept. of Social Services  
Commissioner's Office

RE: Connecticut 13-029

Dear Mr. Bremby:

We have reviewed the proposed amendment to Attachments 4.19-A, of your Medicaid State plan submitted under transmittal number (TN) 13-029. This amendment revises reimbursement for inpatient hospital services. Specifically, it revises the inpatient hospital supplemental payment pool for specified acute care hospitals. The total for state fiscal years (SFYs) 2014 and 2015 will be \$229.8 million (\$214.7M and \$15.1M) and \$95.6 million (\$80.5M and \$15.1M) respectively. Additionally, it authorizes the pool amount of \$15.1M each year with defined criteria.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a) and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447. We are pleased to inform you that Medicaid State plan amendment 13-029 is approved effective July 1, 2013. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Novena James-Hailey at (617) 565-1291.

Sincerely,

A handwritten signature in black ink that reads "Cindy Mann". The signature is written in a cursive, flowing style.

Cindy Mann  
Director

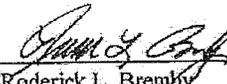
<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> <b>FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>	1. TRANSMITTAL NUMBER: 13-029	2. STATE: CT
	3. PROGRAM IDENTIFICATION; TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE 07/01/2013	
5. TYPE OF STATE PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT		

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: Section 1905 (a)(1) of the Social Security Act 42 CFR 440.10 and 42 CFR 447.253(a)(b)and(c)	7. FEDERAL BUDGET IMPACT: a. FFY 2013      \$28.7 million b. FFY 2014      \$98.1 million c. FFY 2015      \$35.9 million
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-A Page 1 (viii)	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (if applicable) Attachment 4.19-A Page 1 (viii)

10. SUBJECT OF AMENDMENT: Effective July 1, 2013, this SPA proposes to make hospital inpatient supplemental payments of \$229.8 million in State Fiscal Year 2014 and \$95.6 million in State Fiscal Year 2015. The federal budget impact is \$28.7 million in Federal Fiscal Year 2013, \$98.1 million in Federal Fiscal Year 2014, and \$35.9 million in Federal Fiscal Year 2015.

11. GOVERNOR'S REVIEW (Check One):  
 GOVERNOR'S OFFICE REPORTED NO COMMENT  
 COMMENTS OF GOVERNOR'S OFFICE ENCL  
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL  
 OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO:  State of Connecticut Department of Social Services 25 Sigourney Street Hartford, CT 06106-5033  Attention: Ginny Mahoney, Medical Policy
TYPED NAME: Roderick L. Bremby	
14. TITLE: Commissioner	
15. DATE SUBMITTED: September 26, 2013	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: DEC 20 2013
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PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIALS Jul 01 2013	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Penny Thompson	22. TITLE: Deputy Director, Policy & Financial Mgt. CMS
23. REMARKS:	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Connecticut

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- (b) As a rate of payment to hospitals for cost settlement purposes, the Department will pay: (1) for the first seven days of hospital care for patients who no longer require acute care, a rate which is equal to fifty percent (50%) of the hospital's non-intensive care per diem rate; (2) for the eight through fourteenth day of such care, a rate which is equal to seventy-five percent (75%) of the hospital's non-intensive care unit per diem rate; and (3) for days of such care after the fourteenth day, a rate equal to one hundred percent (100%) of the hospital's non-intensive care unit per diem rate.

- (2 A) Supplemental Reimbursement for Inpatient Hospital Services. Supplemental payments to eligible hospitals shall be made from a pool of funds in the amount of \$229.8 million for the year ending June 30, 2014 and \$95.6 million for the year ending June 30, 2015. The payments shall be made periodically throughout each fiscal year. The payments are comprised of two pools:

A pool of \$214.7 million for the year ending June 30, 2014 and a pool of \$80.5 million for the year ending June 30, 2015:

- (a) Hospitals eligible for supplemental payments under this paragraph are short-term general hospitals other than short-term Children's General Hospitals and short-term acute care hospitals operated exclusively by the State, other than a short-term acute care 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 inpatient revenues of all eligible hospitals in the aggregate. For purposes of this supplemental payment, "Medicaid inpatient revenues" means payments for Medicaid inpatient hospital services provided in federal fiscal year 2010 to each eligible hospital up to \$25 million per year per hospital as reported in each hospital's filing with the State of Connecticut Office of Health Care Access (OHCA).

A pool of \$15.1 million per year for the years ending June 30, 2014 and June 30, 2015:

Qualifying hospitals are those described in the pool above that also meet all of the following criteria:

- (1) Medicaid case rate lower than the weighted average, (2) expense per case mix adjusted equivalent discharge lower than the weighted average, and (3) combined Medicare and Medicaid payer mix higher than the weighted average. Criteria are based on the current case rates and each hospital's most recent finalized filing with OHCA. Qualifiers shall be redetermined annually.

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Allocation to qualifying hospitals shall be calculated as follows: (1) A minimum case rate shall be calculated based on the current case rates for qualifying hospitals and the funding available of \$15.1 million. (2) The difference between each hospital's case rate and the minimum is multiplied by Medicaid discharges for the qualifying year to determine each hospital's share of the supplemental payment. (3) The minimum annual payment to a qualified hospital shall be \$100,000.