

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Connecticut

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.