

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Connecticut

Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

- (1) The basis for payment is the Medicare retrospective reasonable cost reimbursement methodology for prospective payment system-exempt hospitals in effect prior to adoption of the Balanced Budget Act of 1997 (Medicare TEFRA Reimbursement Principles).
- (a) In reimbursing for inpatient hospital services to Connecticut hospitals provided under the State Plan, the State agency will apply Medicare standards and principles for prospective payment system-exempt hospitals as specified in 42 U.S.C. § 1395ww, as amended through August 15, 1995 by various acts, including, but not limited to, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), § 4005 of the Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, 104 Stat. 1388 (1990) (OBRA '90) and the Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66 ("OBRA '93"); and federal regulations under TEFRA, OBRA '90, and OBRA '93 in effect on August 15, 1995, including, but not limited to, 42 C.F.R. §§413.40(a)C1 et seq. and 413.86. This federal methodology shall apply except effective October 1, 2001 there shall be an update to a hospital's target amount per discharge to the actual allowable cost per discharge based upon the 1999 cost report filing multiplied by sixty-two and one-half percent if such amount is higher than the target amount per discharge for the rate period beginning October 1, 2000, as adjusted for the ten per cent incentive identified in Section 4005 of Public Law 101-508. If a hospital's allowable cost per discharge is increased to sixty-two and one-half percent of the 1999 cost per discharge, the hospital shall not receive the ten per cent incentive identified in Section 4005 of Public Law 101-508. Effective August 1, 2003, heart and liver transplants shall be reimbursed utilizing payment rates authorized under the Medicare program. Effective April 1, 2005, the revised target amount per discharge for each hospital with a target amount per discharge less than three thousand seven hundred fifty dollars shall be three thousand seven hundred fifty dollars. Effective October 1, 2006, the revised target amount per discharge for each hospital with a target amount per discharge less than four thousand dollars shall be four thousand dollars. For the rate periods between October 1, 2002 and September 30, 2009, there shall be no application of an annual adjustment factor to the target amount per discharge. Effective October 1, 2007, the revised target amount per discharge shall be the higher of (1) the hospital's 2007 Medicaid Cost Per Discharge Target (with addition of ten percent incentive, if applicable) increased by 6.5%; or (2) 80% of the cost per discharge per the 2005 cost report filings, but not to exceed \$10,750 per discharge or 142.5% of the 2007 Medicaid Cost Per Discharge (with addition of ten percent incentive, if applicable). **Effective April 1, 2009, general acute care hospital inpatient rates do not apply to admissions that meet the criteria established in section 1.m of the Addendum to Attachments 3.1-A and 3.1-B, Page 1(b).**
- (b) In reimbursing for inpatient hospital services to out-of-state and border hospitals the State agency will apply the following methodologies:
1. A fixed percentage shall be calculated by the State agency based on the ratio between the allowed cost for all Connecticut in-state hospitals, applying Medicare retrospective reasonable cost reimbursement principles, and total customary charges for all Connecticut instate hospitals, or
 2. Each out-of-state and border hospital may have its fixed percentage optionally determined based on its total allowable cost under Medicare principles of reimbursement pursuant to 42 CFR 413. The State agency shall determine from the hospital's most recently available Medicare cost report filed with the State agency the ratio of total allowable inpatient costs to gross inpatient revenue. The resulting ratio shall be the hospital's fixed percentage not to exceed one hundred percent (100%).

State: CONNECTICUT

**AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
CATEGORICALLY NEEDY GROUP(S): ALL**

1. Inpatient Hospital Services - With Limitations as follows:
 - a. Diagnostic, therapeutic or treatment procedures, and inpatient hospital stays for experimental, cosmetic, research, social or educational purposes;
 - b. Any services or items furnished for which the provider does not usually charge;
 - c. The day of discharge or transfer;
 - d. Leave of Absence (LOA) or Pass without medical permission;
 - e. Leave of Absence (LOA) or Pass with and without Medical Permission, when the Title XIX patient is out of the hospital at the time of the census count (12 Midnight);
 - f. Emergency room services provided on the same day as inpatient admission;
 - g. pacemakers
 - h. Hospital inpatient stay is not covered when the following procedures or services are performed:
 1. Tuboplasty and sterilization reversal
 2. Inpatient charges related to autopsy
 3. All services or procedures of a plastic or cosmetic nature performed for reconstructive purposes, including but not limited to the following:lipectomy, hair transplant, rhinoplasty, dermabrasion, chemabrasion.
 4. Transsexual surgical procedures for gender change or reassignment or treatment preparatory to transsexual procedures (e.g. hormone therapy and electrolysis).
 5. The Department shall pay for surgical services necessary to treat morbid obesity when another medical illness is caused by, or is aggravated by, the obesity. Such illnesses shall include illnesses of the endocrine system or the cardio-pulmonary system, or physical trauma associated with the orthopedic system. For the purposes of this section, "morbid obesity" means "morbid obesity" as defined by the International Classification of Diseases (ICD, as amended from time to time.

State: CONNECTICUT

**AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
CATEGORICALLY NEEDY GROUP(S): ALL**

- i. The Department will not pay for drugs included in the Drug Efficacy Study Implementation (DESI) Program that the Food and Drug Administration has proposed to withdraw from the market in a notice of opportunity for hearing.
- j. Admissions and day(s) of care that do not meet established requirements for medically necessary acute care inpatient hospital services.
- k. Payment will be denied for general hospital inpatient recipients if the Department determines that the medical care, treatment or service does not or did not meet the established medically necessary and/or utilization review standard in accordance with generally accepted criteria and standards of medical practice, or if they do not or did not comply with the other policies, procedures, conditions and limitations established by the Department. This determination may be made at the time of prior authorization, preadmission review, or retrospective review. The fact that a denial was not made at an earlier stage shall not preclude such a determination at a later stage. The Department is entitled to disallow the entirety or any portion of the stay and services provided they do not meet the medically necessary or utilization review standard.
- l. General acute care hospital inpatient stay is not covered if:
 1. the patient acquires a hospital acquired condition during the stay, or
 2. the stay is the result of a hospital acquired condition, and
 3. the hospital acquired condition is among the list of non-reimbursable hospital acquired conditions established pursuant to section 5001(c) of the Deficit Reduction Act (DRA) of 2005, with exceptions as determined by the Department.

TN# 09-003
Supersedes
TN # 07-013

Approval Date _____

Effective Date: 4-01-09

State: CONNECTICUT

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
CATEGORICALLY NEEDY GROUP(S): ALL

2. Outpatient Hospital Services

- a. No more than one (1) visit per day to the same outpatient clinic.
- b. No more than one (1) psychiatric/psychological reevaluation per year per hospital for the same recipient.

3. Other Laboratory and X-Ray Services

No limitation on services.

TN# 09-003
Supersedes
TN # 07-013

Approval Date _____

Effective Date: 4-01-09

State: CONNECTICUT

**AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL**

1. Inpatient Hospital Services - With Limitations as follows:
 - a. Diagnostic, therapeutic or treatment procedures, and inpatient hospital stays for experimental, cosmetic, research, social or educational purposes;
 - b. Any services or items furnished for which the provider does not usually charge;
 - c. The day of discharge or transfer;
 - d. Leave of Absence (LOA) or Pass without medical permission;
 - e. Leave of Absence (LOA) or Pass with and without Medical Permission, when the Title XIX patient is out of the hospital at the time of the census count (12 Midnight);
 - f. Emergency room services provided on the same day as inpatient admission;
 - g. Pacemakers
 - h. Hospital inpatient stay is not covered when the following procedures or services are performed:
 1. Tuboplasty and sterilization reversal
 2. Inpatient charges related to autopsy
 3. All services or procedures of a plastic or cosmetic nature performed for reconstructive purposes, including but not limited to the following:lipectomy, hair transplant, rhinoplasty, dermabrasion, chemabrasion.
 4. Transsexual surgical procedures for gender change or reassignment or treatment preparatory to transsexual procedures (e.g. hormone therapy and electrolysis).
 5. The Department shall pay for surgical services necessary to treat morbid obesity when another medical illness is caused by, or is aggravated by, the obesity. Such illnesses shall include illnesses of the endocrine system or the cardio-pulmonary system, or physical trauma associated with the orthopedic system. For the purposes of this section, "morbid obesity" means "morbid obesity" as defined by the International Classification of Diseases (ICD, as amended from time to time.

State: CONNECTICUT

**AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL**

- i. The Department will not pay for drugs included in the Drug Efficacy Study Implementation (DESI) Program that the Food and Drug Administration has proposed to withdraw from the market in a notice of opportunity for hearing.
- j. Admissions and day(s) of care that do not meet established requirements for medically necessary acute care inpatient hospital services.
- k. Payment will be denied for general hospital inpatient recipients if the Department determines that the medical care, treatment or service does not or did not meet the established medically necessary and/or utilization review standard in accordance with generally accepted criteria and standards of medical practice, or if they do not or did not comply with the other policies, procedures, conditions and limitations established by the Department. This determination may be made at the time of prior authorization, preadmission review, or retrospective review. The fact that a denial was not made at an earlier stage shall not preclude such a determination at a later stage. The Department is entitled to disallow the entirety or any portion of the stay and services provided they do not meet the medically necessary or utilization review standard.
- l. General acute care hospital inpatient stay is not covered if:
 1. the patient acquires a hospital acquired condition during the stay, or
 2. the stay is the result of a hospital acquired condition, and
 3. the hospital acquired condition is among the list of non-reimbursable hospital acquired conditions established pursuant to section 5001(c) of the Deficit Reduction Act (DRA) of 2005, with exceptions as determined by the Department.

TN# 09-003
Supersedes
TN # 07-013

Approval Date _____

Effective Date: 4-01-09

State: CONNECTICUT

**AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL**

2. Outpatient Hospital Services

- a. No more than one (1) visit per day to the same outpatient clinic.
- b. No more than one (1) psychiatric/psychological reevaluation per year per hospital for the same recipient.

3. Other Laboratory and X-Ray Services

No limitation on services.

**TN# 09-003
Supersedes
TN # 07-013**

Approval Date _____

Effective Date: 4-01-09