

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Connecticut

- (15) Additional Disproportionate Share payments for Hospitals Serving Low-income Persons under SSA Section 1923 (c) (3).

CRITERIA – In addition to the mandatory disproportionate share hospital (DSH) payment adjustment to inpatient hospital rates, DSH providers are those lawfully operated general hospitals in Connecticut and comparable out-of-state border hospitals that provide services to low-income persons.

In addition, each hospital in order to be eligible must meet the requirements of Section 1923 (d) of the Social Security Act.

PAYMENT ADJUSTMENTS – When the admitting diagnosis is medical and for dates of service on or after January 1, 2004, monthly payments are made to the above-qualified hospitals as a percentage of the cost incurred by each hospital in rendering inpatient and outpatient services to low-income persons. For the purpose of this DSH designation, low-income population is defined as persons eligible for the State Administered General Assistance medical program.

The Commissioner of Social Services determines the amount of the disproportionate share payments to be made under this section based on the authorized budget for the current fiscal year and claims submitted by hospitals for processing with dates of service on or after January 1, 2004.

Part A: The authorized budget for first quarter of SFY 2010 is \$15.03 million for the portion of Section 15 of the state plan pertaining to inpatient and outpatient hospital services, excluding outpatient clinic services and associated ancillary services.

Payments shall be made to each of the qualifying short-term general hospitals beginning April 2004 and thereafter on a monthly basis as follows:

- (A) Determine the cost of inpatient and outpatient hospital services rendered by each hospital by calculating the number of days of inpatient services provided to recipients of the State Administered General Assistance program multiplied by the Medicaid per diem rate plus the number of units

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of outpatient services provided to recipients of the State Administered General Assistance program multiplied by the corresponding Medicaid rate. Include only days and units of service with dates of service January 1, 2004 through July 31, 2004. Exclude days and units of service included in the calculation of cost for previous monthly payments under this provision.

- (B) Determine the cost of inpatient and outpatient hospital services, excluding outpatient clinic services and associated ancillary services, rendered by each hospital by calculating the number of days of inpatient services provided to recipients of the State Administered General Assistance program multiplied by the Medicaid per diem rate plus the number of units of outpatient services provided to recipients of the State Administered General Assistance program multiplied by the corresponding Medicaid rate. Include only days and units of service with dates of service on or after August 1, 2004. Exclude days and units of service included in the calculation of cost for previous monthly payments under this provision.
- (C) Calculate the sum of the result of (A) and (B) for all hospitals.
- (D) Divide the result of the sum of (A) and (B) for each hospital by the result of (C).
- (E) Multiply the amount available for disproportionate share payments by the result of (D).

Part B: Additional payments for hospital outpatient clinic services and associated ancillary services shall be made to each of the qualifying short-term general hospitals beginning August 2004 and thereafter on a monthly or more frequent basis. The methodology used to calculate the payments is determined by calculating the number of units of hospital outpatient clinic services and associated ancillary services provided to recipients of the State Administered General Assistance program multiplied by the corresponding Medicaid rate. The calculation shall include only units of service with dates of service on or after August 1, 2004.

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Medicaid payments for hospital outpatient clinic services (500 series revenue center codes) are made based upon a fixed fee (\$57.23/visit). Fee increases are subject to legislative budget approval. Medicaid payments for hospital outpatient ancillary services are a combination of fixed fees and ratio of cost charges. Forty-three services are paid for based upon fixed fees including, for example, magnetic resonance imaging (\$145.46/test), CT scan (\$145.46/test) and EKG (\$51.94). As with the clinic fee, increases are subject to legislative budget approval. Other ancillary services are updated each July 1 based upon a ratio of costs to charges (RCC) for each service. RCC's are hospital specific. Annual cost report filings by hospitals are used to determine the Medicaid payment ratio (RCC) for each service category (e.g. pharmacy, recovery room, ambulatory surgery). Hospitals are provided with rate letters on an annual basis.

Section 5 of Attachment 4.19A will continue to apply for dates of service prior to January 1, 2004.

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