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Hospital Cost Reimbursement and Rates of Payment
for Administratively Necessary Days**

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**Title XIX Payments to Hospitals, Including Principles of
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Sec. 17-312-101. Principles to be used in computing rates

The principles of hospital cost reimbursement to be used in computing rates pursuant to Section 17-312 (a), (b) and (c) shall be those set forth in Title XVIII of the Social Security Act as amended by Public Law 97-248 i.e., "Medicare" principles as they existed for retrospective reasonable cost reimbursement.

(Effective March 7, 1986)

Sec. 17-312-102. General reimbursement policy

The Department of Income Maintenance (hereinafter the Department) will reimburse inpatient acute care services in accordance with rules set forth herein.

Definitions.

(a) "Admissions" means the same volume of treatment defined as discharges.

(b) "Discharge" means any patient who was discharged at a date subsequent to the date admitted to the hospital for treatment as an inpatient, except that it shall also mean such patient admitted and discharged on the same day where such patient:

- (1) died, or
- (2) left against medical advice.

(c) "Final adjusted target rate" means the total allowable cost per discharge including routine and ancillary costs as set forth in the Medicare Principles of Reimbursement net of excludable costs which are defined in Section 17-312-105 (d) of the regulations.

(d) "Fiscal year" means the hospital fiscal year commencing on October 1 and ending on September 30.

(e) "Hospital" means a hospital included within the definition of health care facilities or institutions under section 19a-145 of the General Statutes and licensed as a short-term general hospital by the Department of Health Services but shall not include a short-term children's general hospital. A hospital included within the definition of health care facilities or institutions under said section but licensed as a mental health facility shall be included within the definition of hospital under this subsection at such time as such hospital is covered by the Medicare prospective payment system.

(f) "Medicaid" refers to medical assistance provided pursuant to chapters 302 and 308 of the General Statutes and Title XIX of the Social Security Act.

(g) "Medicare" refers to Title XVIII of the Social Security Act and to the regulations established pursuant to Title XVIII.

(h) "Medicare Principles of Reimbursement" refers to Title 42 of the Code of Federal Regulations (CFR), subchapter B, Part 405, subpart D and, as may hereafter be amended.

(i) "Rate year" means the fiscal year beginning October 1, for which the hospital's Medicaid reimbursement level is being established.

(j) "Prior year" means the most recently completed fiscal year.

(k) "TEFRA allowed amounts" means the amounts allowable under the Federal Tax Equity and Fiscal Responsibility Act of 1983.

(l) "TEFRA base year" means the hospital's fiscal year ending in calendar year 1982.

(m) "Rate Period" means the fiscal year that an interim per diem rate is determined.

(n) “Interim Per Diem Rate” means the rate as calculated pursuant to Section 17-312-103 (a).

(Effective January 19, 1988)

Sec. 17-312-103. Medicaid interim per diem rate

(a) Interim Rate Computation

The Department will reimburse inpatient acute care services based on an interim per diem rate subject to cost settlement per Section 17-312-104 (b) of these regulations.

(b) The interim rate is calculated for each hospital as follows:

The target amount per discharge from the most recently filed cost report will be increased by the estimated TEFRA update factors from the cost report period to the interim rate period. The product will be the rate period estimated target amount per discharge.

The Department will divide the estimated target amount per discharge by the average length of stay as calculated from the most recently filed cost report to determine an interim per diem rate of payment. To this quotient will be added the estimated per diem costs of those items excludable from the TEFRA calculation as defined in Section 17-312-105 (d) of these regulations. The sum of this calculation is the Medicaid interim per diem rate.

(c) Information and Notification

Information Requirements

All hospitals must provide adequate cost data annually based on financial and statistical records for the year ending September 30. The hospital must submit a cost report each year on forms prescribed by the Department. The Department requires that these reports be completed and filed within 60 days after issuance. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. If the filing is not done on a timely basis, the Department may withhold payment to the provider.

(Effective January 19, 1988)

Sec. 17-312-104. Determination of TEFRA reimbursement level

(a) TEFRA Payment Methodology

The Department will determine Medicaid allowable inpatient costs pursuant to TEFRA principles of reimbursement. The components of Medicaid allowable inpatient cost will be determined in the following manner:

(1) Computation of Target Rates

(A) Base Costs for Computing Target Rates

Target rates will be based on the provider’s fiscal year ending during the calendar year 1982. The Department will use the appropriate cost and statistical data from the provider’s TEFRA base year. The Department will calculate the total Medicaid allowable inpatient cost by applying Medicare Principles of Reimbursement in effect at that time. The Medicaid allowable inpatient cost is divided by the number of Medicaid discharges to produce the TEFRA base year operating cost per discharge. Hospital based physicians, capital, direct medical education, malpractice and kidney acquisition costs, as determined by using Medicare principles of reimbursement, will be excluded from this calculation. The methodology for computing the TEFRA Base Year Operating Cost per Discharge (BPOR) is defined as:

$$\text{BPOR} = \text{OC} / \text{D}$$

where: OC=Total Title XIX Inpatient Operating Cost for the TEFRA base year net of excludable cost (Form HCFA-2552, Worksheet D-1, Part II, line 56).
D=Medicaid discharges for the hospital’s TEFRA base year.

(B) Annual Adjustment Factor

To compute the TEFRA allowed amount, the Department will continue to use the update factor used by Medicare to revise the yearly rates for nonparticipating PPS hospitals and units. The update factor is published annually in the Federal Register.

(C) Computation of Hospital Target Rates

The hospital specific final target rate will be calculated by multiplying the TEFRA Base Year Operating Cost per Discharge by the accumulated update factor from the TEFRA base year to the cost report.

(2) Determination of Allowable Costs for the Cost Report Year

Once the Department determines the costs which are allowable pursuant to the Medicare principles of reimbursement, the Department determines which costs are applicable to the Medicaid program. Ancillary costs are determined by a ratio of total cost to total charges factor. This ratio is applied to Medicaid charges for the various ancillary cost centers. Routine costs are determined by computing the cost per day. This amount is multiplied by the total number of Medicaid days. The total allowable cost including routine and ancillary costs net of excludable costs is then compared to the final target amount. The total allowable costs are divided by the Medicaid discharges to determine the allowable cost per discharge.

If the hospital's allowable costs per discharge is greater than their hospital specific final target rate then the Department will not consider as Medicaid allowable inpatient costs any costs above the hospital specific final target rate.

If the hospital's allowable costs per discharge is less than their hospital specific final target rate, the Department will consider the Medicaid allowable inpatient costs to be allowable costs per discharge plus (a) 50% of the difference between the allowable costs per discharge and the hospital specific final target rate, or (b) 5% of the hospital specific final target rate, whichever is less.

(3) Determination of Total TEFRA Allowable Payments

Total TEFRA allowable payments for the year will be based on total allowable costs, as defined to be the sum of:

(A) allowable Title XIX costs for malpractice, hospital based physicians, capital, medical education, and kidney acquisition, as set forth in Section 17-312-105 (d) and

(B) allowable inpatient routine and ancillary costs, and

(C) the allowable incentive as defined in Section 17-312-104 (2) of these regulations.

(b) Allowed Payments under TEFRA for the Medicaid Program—Cost Settlement

The total allowed payment under TEFRA will be the sum of all allowable costs as determined above for each hospital. The total allowed costs will be compared to the interim payments made by the Department plus other payments made on behalf of Title XIX recipients, and the amount owed to the State or to the hospital pursuant to cost settlement will be paid.

(Effective January 19, 1988)

Sec. 17-312-105. Other related information**(a) Rebasing**

After the implementation year, the Commissioner may in his sole discretion, select a new base period using actual cost data from more recent years for prospectively determining the target rate in the event that he determines that to do so is appropriate, equitable and does not prejudice the interests of the State.

(b) Allowable and Nonallowable Costs

Allowable costs, nonallowable costs, and reasonableness of costs will be based on Medicare principles of reimbursement as defined in Section 17-312-102.

(c) **Reporting Year**

For the purpose of determining payment rates, the reporting year is the hospital's fiscal year.

(d) **Excludable costs**

The Department will reimburse hospitals for hospital based physicians, capital, direct medical education, malpractice, and kidney acquisition costs attributable to Medicaid based on Medicare principles of reimbursement.

(e) **Change of Ownership Resulting From a Sale or Lease**

When a sale or lease occurs, the provider's target rate basis will remain the same as before the transaction.

(f) **Retention of Records**

Each hospital will maintain financial and statistical records of the period covered by such cost reports for a period of not less than ten years following the date of submittal of the cost report to the Department. These records must be accurate and in sufficient detail to substantiate the cost data reported. The provider will make such records or copies thereof available upon demand to the Department, or its representatives.

(g) **Audits**

(1) Desk Audit

Each cost report will be subjected to a review to ensure completeness, appropriateness and accuracy.

(2) Field Audit

Field audits will be performed on a timetable determined by the Department. The purpose of the field audit of the facility's financial and statistical records is to verify that the data submitted on the cost report is accurate, complete and reasonable. The field audits are conducted in conformity with Medicare regulations and are of sufficient scope to determine that only proper items of cost applicable to the services furnished were included in the provider's calculation of its costs and to determine whether the expense attributable to such proper items of cost were accurately determined to be reasonable. Any item not supported by adequate documentation or which is found to be unallowable will be disallowed by field audit. Proper adjustments to future payments will be made to recover amounts determined by field audit to be overpayments.

(h) Whenever a Medicare cost report is reopened, the result of the reopening will be applied to the Medicaid cost report.

(i) Notwithstanding any of the above provisions, any requirements mandated by changes in Federal law applicable to the Medicaid program shall be hereby incorporated into these regulations and shall supersede any contrary provision of these regulations.

(Effective January 19, 1988)

Sec. 17-312-106. Free-standing chronic disease hospitals with over 50% medicaid patient days

(a) **Commission Rate Order.** A chronic disease hospital having more than an average of 50% of its inpatient days paid for by the Department may seek to obtain an adjustment of reimbursement from the Department. In order to be considered it shall submit, within thirty (30) days of the issuance of a final uncontested order by the Commission on Hospitals and Health Care (Commission) a copy of such rate

order together with a schedule of the hospital's rates and charges as filed with the Commission in compliance with such rate order.

(b) **All-Inclusive Rate.** The Commissioner may establish, based upon consideration of the Commission rate order and upon documents submitted to the Department by the hospital, and the cost elements set forth in Section 17-312 (c) of the General Statutes, and any other information the Commissioner deems appropriate, an annualized interim all-inclusive per diem rate including routine services and ancillary services, to be paid by the Department to the hospital effective with the date authorized by the Commission.

(c) **Year-end Settlement.** Each chronic disease hospital reimbursed in accordance with this section shall submit to the Department, within sixty (60) days following the end of the hospital's fiscal year, a verified complete statement of actual utilization of hospital routine and ancillary services by patients paid for by the Department. Services may be paid for based upon consideration of the rates approved by the Commission for said services and the cost elements set forth in Section 17-312 (c) of the General Statutes. Any amount owed to the Department or owing to the provider will be calculated by comparing actual routine and ancillary services utilized during the period to the interim all-inclusive per diem rate. Within sixty (60) days of receipt of the data submitted by the hospital, the Commissioner shall determine, based upon the data and upon such reviews of it as he shall deem necessary, the amount owed either by the Department to the hospital or by the hospital to the Department and shall forward to the hospital a statement reflecting that determination. That amount shall be paid within sixty (60) days of the hospital's receipt of the statement of balance owed.

(Effective April 19, 1988)

Sec. 17-312-107. Disproportionate share adjustment

For purposes of this regulation, the following definitions apply:

(a) **Definitions**

(1) "Medicaid inpatient utilization"—For a hospital, the total number of its Medicaid inpatient days including newborn in a cost reporting period, divided by the total number of the hospital's inpatient days including newborn in that same period.

(2) "Low-income utilization rate"—For a hospital, the sum (expressed as a percentage) of the fraction, calculated as follows:

(A) Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from State and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; and,

(B) The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medical assistance under an approved Medicaid State plan) that is, reductions in charges given to other third-party payers, such as HMOs, Medicare or Blue Cross.

(b) Effective for the fiscal year ending September 30, 1989 and subsequent fiscal years hospitals which meet at least one of the following criteria shall be eligible for a disproportionate share adjustment.

(1) A Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for hospitals receiving Medicaid payments in the State.

(2) A low-income inpatient utilization rate exceeding 25 percent.

(c) If the hospital meets one of the criteria in subsection (b), it must also have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the State Medicaid plan.

(d) The Department shall determine from available Medicaid cost reports which hospitals meet the criteria of subsection (b) (1). Hospitals that believe they meet the criteria of subsection (b) (2) must file with the Department by August 1st of each year their calculation that the low-income inpatient utilization rate exceeded 25 percent for the most recently completed fiscal year.

(e) In calculating interim rates pursuant to section 17-312-103 of these regulations, hospitals that qualify for a disproportionate share adjustment shall have its estimated TEFRA target amount increased by the available Medicare disproportionate share adjustment percentage as determined by the Medicare fiscal intermediary.

(f) A hospital that received an adjustment as a disproportionate share hospital in its interim per diem rate shall receive in its final target rate calculated pursuant to Section 17-312-104 of these regulations the same adjustment percentage as set forth in subsection (e) above.

(Effective June 26, 1989)

Secs. 17-312-108—17-312-200. Reserved

Sec. 17-312-201. Non-required acute hospital care

For hospital patients who no longer require acute hospital care, the Department will only pay for those patients who qualify for Medicaid certified Skilled Nursing Facility or Intermediate Care Facility services at the rate established pursuant to Section 17-312-101 and specified below in Section 17-312-202 and 17-312-203.

(Effective March 7, 1986)

Sec. 17-312-202. Interim rate of payment to hospitals

As an interim rate of payment to hospitals, prior to cost settlement, 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 interim non-intensive care per diem rate; (2) for the eighth through fourteenth day of such care a rate which is equal to seventy-five percent (75%) of the hospital's interim non-intensive care 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 interim non-intensive care per diem rate.

(Effective March 7, 1986)

Sec. 17-312-203. Rate of payment to hospitals for cost settlement purposes

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 hospitals non-intensive care per diem rate; (2) for the eighth 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.

(Effective March 7, 1986)