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MEMORANDUM

To: Hospital Clients

From: Robert D. Tobin
Thomas J. Riley

Date: August 20, 2003

Re: Changes in SAGA Medical Assistance Program

As part of implementation of the budget last week, the Legislature enacted significant changes to the SAGA medical assistance program. Effective October 1, 2003, this program is no longer considered an entitlement, which has significant implications for the State's obligation to pay for inpatient care provided to those who receive SAGA benefits, or are eligible to receive retroactive SAGA medical assistance after their hospital stay. In the past, the State has paid on a fee for service basis for inpatient hospital care provided to this class of persons with no cap on the spending. Each hospital which treated SAGA beneficiaries received payment at the per diem rate for the services provided to the patient. If the total of all payments to hospitals exceeded the budgeted figure, the State still made the payments.

From now on, the total liability of the State for inpatient care provided to SAGA recipients will be capped at the annual budgeted figure. In essence, the hospitals will be competing for shares of this limited pool of money. For the fiscal year 2004, beginning on October 1, for example, the State anticipates allocating about \$15 million dollars less to inpatient care under the SAGA program than it would pay under the old system, a reduction of about 20%. At the end of each quarter, the State will divide up a portion of this pool of money among the hospitals which treated SAGA eligible patients in that quarter. The precise formula for allocating shares of the pool has not been developed yet, but it will take account of the number of SAGA eligible patients treated and the cost of services provided to them.

The first payments under the new formula will be made in January 2004 for the last quarter of 2003. It is imperative that you take steps now to maximum your potential to collect payments under the new formula for care provided to SAGA eligible patients.

As always, we at TCORS are uniquely well-positioned to assist you in this regard. We have been representing hospitals in the medical assistance arena for over 40 years, and will continue to

do so under the new system. The following are some critical factors to keep in mind as you manage your uninsured caseload in the months to come.

1. The new legislation makes no change in Medicaid eligibility or payment methodology. You should strive to qualify as many patients as possible for Medicaid coverage. We have extensive experience in this area.
2. Given the limited funding, it is even more important now, than before, to be sure that all patients who are eligible for SAGA assistance qualify for such assistance. Do not limit yourself to claims for treatment of persons who were receiving SAGA assistance when they were admitted. Scrutinize those patients who are uninsured, and not yet eligible for SAGA, to determine if they can qualify for retroactive Medicaid and SAGA benefits. Getting these potentially eligible patients qualified will directly increase your share of the pool of funds available for inpatient care under SAGA. Remember too that some of them might qualify for Medicaid benefits.
3. The new legislation preserves the right to seek a fair hearing at DSS to challenge a denial of SAGA or Medicaid assistance, so do not take "No" for an answer. Refer to us cases which are denied. If DSS has not acted on the application within 40 days, send us these cases as well. The time for filing an appeal of a denied case is limited to 60 days from the denial date. We also can submit an initial application or reapplication up to the last day of the third month following the hospital stay. For example, we have until April 30th to file an application or reapplication for a patient treated in January.
4. Our highly experienced attorneys and paralegals can determine whether to submit a new application seeking retroactive assistance or appeal the denial. Using such tools as our authorized representative form, subpoenas and investigators, we often can supply the information needed to force DSS to act on an application, to turn a denial into an approval, or to successfully appeal a denial.
5. Identifying potentially eligible patients, and qualifying them for benefits, will maximize your share of the limited funding for inpatient treatment of SAGA eligible patients.

Our Government Relations staff was intimately involved in monitoring the legislative process which led to these changes. We fought hard to maintain the previous payment system. We will be as involved in monitoring development of the formula for allocating the capped funding for hospitals, and attempting to ensure it is fair to all. We will keep you up to date on development of the formula and regulations to implement the new law.

As always, if you have questions or concerns about these changes or their impact on your operations, or want to review a specific case for eligibility, feel free to call one of us.

OLR SUMMARY

- The bill requires the DSS commissioner to implement a state medical assistance program as a component of the SAGA program for people ineligible for Medicaid.
- It also makes these individuals eligible for hospital services.
- The bill requires the commissioner, within available appropriations, to pay hospitals for inpatient services based on their pro rata share of the cost of services provided, the number of clients served, or both.
- The bill requires that the income eligibility criteria for SAGA medical assistance be the same as the "medically needy component" of the Medicaid program except it allows DSS to disregard up to \$150 of monthly earned income.
- The income limit for that program is 143% of the TFA need standard for the assistance unit's size.
- Commissioner to apply for a federal Health Insurance Flexibility and Accountability (HIFA) waiver by March 1, 2004 to increase the number of SAGA-eligible individuals who can get Medicaid coverage. (HIFA allows states to use either Medicaid or federal State Children's Health Insurance Program (SCHIP) funds to pay for health care initiatives that cover individuals not traditionally served by those programs.) The existing legislative waiver approval process applies to this waiver.
- The bill continues to permit applicants or recipients of SAGA (both cash and medical assistance) who are aggrieved by a DSS commissioner decision to request an administrative hearing.
- The bill requires the DSS commissioner to implement policies and procedures necessary to carry out the bill's provisions regarding SAGA, including the appeals, while in the process of adopting regulations. She must publish notice of intent in the *Connecticut Law Journal* within 20 days of implementation. The policies and procedures are valid until the final regulations are adopted.
- Sections 42-49, 97. This section prohibits any town from receiving state reimbursement for any services after March 1, 2004. Currently, only Norwich operates its own general assistance program.
- Eligibility and entitlement status does not change for individuals in SAGA. However, medical payments to health centers and hospitals are subject to available appropriations.