DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 18-Y Discontinuing coverage of non surgical birth control device

The State of Connecticut Department of Social Services (DSS) proposes to submit the following Medicaid State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS).

Changes to Medicaid State Plan

Based on a recent sale restriction issued by the FDA, DSS will no longer cover non-surgical, non-hormonal implanted birth control devices or any similar device due to concerns about harmful medical side effects.

Effective for dates of service August 1, 2018 and forward, the permanent implantable contraceptive intratubal occlusion device and delivery system that is used as part of bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants procedure will no longer be covered under the Healthcare Common Procedure Coding System (HCPCS) code A4264-Intratubal occlusion device. Other birth control devices such as the Falope ring and filshie clips remain covered and should continue to be billed under HCPCS code A4264.

Additionally, Current Procedure Terminology (CPT) code 58565-Hysteroscopy sterilization will be end-dated for dates of service, August 1, 2018 and forward on the following fee schedules: physician-surgical, ambulatory surgical centers, and family planning clinics. The CPT code will be changed to a "no" under the payment type column on the Connecticut Medical Assistance Program Addendum B for outpatient hospitals.

Fee schedules are published at this link: http://www.ctdssmap.com, then select "Provider", then select "Provider Fee Schedule Download." This SPA is necessary in order to comply with federal requirements regarding the reimbursement for drugs provided in the settings described above.

Fiscal Information

DSS estimates that this SPA will result in a gross decrease in Medicaid expenditures of approximately $20,161 in State Fiscal Year (SFY) 2019 and $24,919 in SFY 2020.

Obtaining SPA Language and Submitting Comments

The proposed SPA is posted on the DSS website at this link: http://portal.ct.gov/dss. Scroll down to the bottom of the webpage and click on "Publications" and then click on "Updates." Then click on "Medicaid State Plan Amendments". The proposed SPA may also be obtained at any DSS field office, at the Town of Vernon Social Services Department, or upon request from DSS (see below).

To request a copy of the SPA from DSS or to send comments about the SPA, please email: Public.Comment.DSS@ct.gov or write to: Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105 (Phone: 860-424-5067). Please reference "SPA 18-Y Revision to LARC Device Coverage".

Anyone may send DSS written comments about this SPA. Written comments must be received by DSS at the above contact information no later than July 26, 2018.

(5) Physician's services – Fixed fee schedule not to exceed the Medicare physician fee schedule. The current fee schedule was set as of August 1, 2018 and is effective for services provided on or after that date. The fee schedule for physicians can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download." All governmental and private providers are reimbursed according to the same fee schedule.

Person-Centered Medical Home (PCMH) practices are individual sites of independent physician groups, solo physician practices, nurse practitioner groups, and individual nurse practitioners that have met National Committee for Quality Assurance (NCQA) Level 2 or Level 3 medical home recognition or NCQA medical home recognition under the 2017 or later NCQA standards (which do not recognize specific levels of recognition). PCMH practices must comply with all NCQA PCMH requirements and all additional written department requirements, including participation in various primary care initiatives operated by the State.

The department offers a PCMH Glide Path program, which pays enhanced rates to practices that are providing some of the additional Medicaid services required for NCQA PCMH recognition. In order to qualify for Glide Path, a practice must demonstrate that it has begun providing a more advanced standard of primary care and has committed to achieving NCQA PCMH recognition in a set period of time. Glide Path practices must also comply with all additional written department requirements, including participation in various primary care initiatives operated by the State.

Beginning January 1, 2012, PCMH and Glide Path practices may be eligible for a rate add-on to the procedure codes on the physician fee schedule identified below. PCMH practices may also be eligible for retrospective annualized supplemental payments for performance incentives and performance improvement. Independent physician-led Glide Path practices with five or fewer full-time equivalent practitioners across all practice locations may also be eligible for a supplemental payment at each Glide Path phase.

(a) Glide Path and PCMH Rate Add-On: The department will pay a rate add-on for the following procedures in addition to the amounts listed for each procedure code on the physician fee schedule: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99339, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99354, 99355, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99406, 99407, 99408, 99409, 99411, 99412, 99374, 99377, 99379, 99380, 96110, 99050, 99051, 99053, D0145,

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9. Clinic services – Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of clinic services and the fee schedule and any annual/periodic adjustments to the fee schedule are published in www.ctdssmap.com. Fees are effective as of the dates noted below, except that fees may be deleted or added and priced in order to remain compliant with HIPAA. Rates for freestanding clinics are set as follows:

(a) Ambulatory Surgical Centers: The current fee schedule was set as of August 1, 2018 and is effective for services provided on or after that date. All rates are published at www.ctdssmap.com.

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(c) Family Planning Clinics: The current fee schedule was set as of August 1, 2018 and is effective for services provided on or after that date. All rates are published at www.ctdssmap.com.