DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

CENTERS FOR MEDICARE & MEDICAID SERVICES

Division of Medicaid and Children's Health Operations / Boston Regional Office

March 4, 2016

Roderick Bremby, Commissioner
Department of Social Services
55 Farmington Avenue
Hartford, CT 06105

Dear Mr. Bremby:

We are pleased to enclose a copy of approved Connecticut State Plan Amendment (SPA) No. 15-018, submitted to my office on June 25, 2015 and approved on February 19, 2016. This SPA amends Attachment 4.19B of the Connecticut State Plan in order to change the reimbursement methodology for the following outpatient hospital services: revenue center codes 403 and 320 and procedure codes 41899. This approved change establishes a fixed fee for those procedures with the intention of improving consistency of outpatient hospital reimbursement across the state.

This SPA has been approved effective April 1, 2015, as requested by the State.

Changes are reflected in the following sections of your approved State Plan:

- Attachment 4.19B, Page 1

If you have any questions regarding this matter you may contact Marie DiMartino (617) 565-9157 or by e-mail at Marie.DiMartino@cms.hhs.gov

Sincerely,

Richard R. McGreal
Associate Regional Administrator

cc: Kate McEvoy, Director of Medical Administration - Health Services and Supports

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 15-018
2. STATE: CT
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: April 1, 2015

5. TYPE OF STATE PLAN MATERIAL (Check One):

___ NEW STATE PLAN ___AMENDMENT TO BE CONSIDERED AS NEW PLAN _X_ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1905(a)(2)(A) of the Social Security Act and 42 CFR 440.20

7. FEDERAL BUDGET IMPACT:
a. FFY 2015 $2.2 million (savings)
b. FFY 2016 $5.2 million (savings)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19B Page 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If applicable)
Attachment 4.19B Page 1

10. SUBJECT OF AMENDMENT: Effective April 1, 2015, SPA 15-018 amends Attachment 4.19-B of the Medicaid State Plan in order to change the reimbursement methodology for the following outpatient hospital services: revenue center codes 403 and 320 and procedure code 41899. This change establishes a fixed fee for those procedures, which are now paid using a hospital-specific ratio of cost to charge. This change is intended to improve consistency of outpatient hospital reimbursement across the state.

11. GOVERNOR'S REVIEW (Check One):

_X_ GOVERNOR'S OFFICE REPORTED NO COMMENT
__ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
__ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
__ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Roderick L. Bremby

14. TITLE: Commissioner

15. DATE SUBMITTED: June 25, 2015

16. RETURN TO:

State of Connecticut
Department of Social Services
55 Farmington Avenue – 9th floor
Hartford, CT 06105
Attention: Ginny Mahoney

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: June 25, 2015

18. DATE APPROVED: February 19, 2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: April 1, 2015

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Richard R. McGreal

22. TITLE: Associate Regional Administrator, Division of Medicaid & Children's Health Op

23. REMARKS:

FORM HCFA-179 (07-92)

 OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Connecticut

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES–OTHER TYPES OF CARE

(2) (a) Outpatient hospital services – The agency reimburses outpatient hospital services using both fixed fees and cost to charge ratios. The agency's fixed fees were set as of April 1, 2015 and are effective for services on or after that date. Fixed fees are published on the Department's website at www.ctdssmap.com. Fixed fees are paid for various categories of outpatient hospital services, including, but not limited to: diagnostic laboratory services, imaging, therapies, group tobacco cessation counseling, behavioral health, and various other categories of service according to the revenue center codes listed in the fee schedule. For revenue center codes not listed on the fee schedule, the rate for each code is based on the hospital-specific cost to charge ratio for each applicable ancillary or outpatient department as designated by the hospital and reported on the hospital's fiscal year 2012 cost report filing, as determined by the Department. The rate schedule is sent to each hospital and is revised annually (July 1) based on the most recently filed cost report. Rates for outpatient hospital services are not reconciled to actual costs.

There are higher fees for outpatient hospital behavioral health services that meet special access and quality standards as enhanced care clinics (ECCs), as noted on the hospital-specific schedule for each hospital that has an ECC. ECCs must accept all (100%) telephonic and walk-in referrals that present during business hours. All referrals must be screened by a trained intake worker or clinician and triaged to determine whether the referral is emergent, urgent or routine. A clinician must evaluate a client who presents at the clinic with an emergent condition within two (2) hours. Clients that undergo telephonic or walk-in screening and are determined to be in urgent need of services must be offered an appointment for an urgent face-to-face clinical evaluation with a clinician to take place within two (2) calendar days of the screening. Clients that undergo telephonic or walk-in screening and are determined to have routine needs must be offered an appointment for a routine face-to-face clinical evaluation with a clinician to take place within 14 calendar days of the screening. ECCs must have at least nine (9) extended hours per week beyond routine business hours of 8:00 AM to 5:00 PM. ECCs have a valid Letter of Agreement with the Department that holds them accountable to the quality standards and access standards receive the enhanced rate for all routine outpatient services provided. The state monitors the access standards on a routine basis and provides access standard reports to the providers on a quarterly basis. The state has established a process for providers to submit corrective action plans (CAPs) if they do not meet the access standards for any reason except in increase in volume in excess of 20% compared to the same quarter of the previous year. ECCs must electronically register appointments made with the Administrative Services Organization (ASO). This process allows for an automated process to track access standards for routine cases. The state also utilizes a mystery shopper process to track access standards. The state also does on-site chart reviews to determine if providers are in compliance with quality standards and the urgent and emergent access standards. As a result of the on-site reviews, CAPs will be required from providers who do not meet quality or access standards reviewed. Fees for services provided to individuals 18 years of age and over are 95% of the published fee for ECCs.

Except as otherwise noted in the plan, state developed fee schedules and rate methods are the same for both governmental and private providers.