DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 18-V: Updates to the Physician Office and Outpatient Fee Schedule

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

Effective on or after July 1, 2018, SPA 18-V will amend Attachment 4.19-B of the Medicaid State Plan to update the physician office and outpatient fee schedule as follows:

- Several procedure codes that are currently manually priced (specifically, codes 36482, 36482, 44381, 44381, 44384, 45388, 45388, 45389, 45390, 45393, 45398, 46601, 46601, 46607, 46607, 48551, 95875, 96377, 99091) will be priced at 57.5% of the 2018 Medicare physician fee schedule.

- The Federal Food & Drug Administration (FDA) approved Heplisav-B, a new Hepatitis-B vaccine to be administered to adults, aged 18 years and older. DSS will add Current Procedure Terminology (CPT) code: 90739-"Hepb vacc, 2 dose adult im". It will be reimbursed at $131.10, which is based on 100% of the April 2018 Medicare Average Sales Price (ASP) Drug Pricing File.

- Effective for dates of service July 1, 2018 and forward, DSS is increasing the reimbursement rate for the following LARC devices on the physician office and outpatient fee schedule as follows:

Code	Description	Price
J7296	Kyleena 19.5 mg	$908.97
J7298	Mirena 52 mg	$908.87
J7301	Skyla 13.5 mg	$756.87
J7307	Etonogestrel implant	$890.30

Additionally, the reimbursement rates for Kyleena, 19.5 mg (HCPCS code J7296) on the family planning clinic fee schedule will be increased to $249.00, effective for dates of service July 1, 2018 and forward.

Reimbursement for LARC devices in the outpatient hospital setting will be determined by the specific HCPCS code billed for the LARC device inserted/placed. The reimbursement rate for LARC devices will be the rate published for the specified procedure code on the physician office and outpatient fee schedule or, for 340B hospitals, the family planning fee schedule.

Inpatient hospitals will be separately reimbursed for a LARC device provided immediately postpartum in the inpatient hospital setting when the LARC device is billed on an outpatient claim. The services related to the labor and delivery provided by the hospital will continue to be billed on the inpatient hospital claim and separate reimbursement for the LARC device will be made to the hospital in addition to the Diagnosis Related Group (DRG) reimbursement for labor and delivery.

- In order to allow HUSKY Health providers to be properly reimbursed for newly introduced, FDA approved vaccines/toxoids and timely access to medically necessary products, CPT code: 90749-"Unlisted vaccine/toxoid" will be added to the physician office & outpatient fee schedule, effective July 1, 2018. This CPT code should only be used when a specific CPT is currently not available for newly FDA approved vaccines/toxoids.

  The pricing for the unlisted vaccines/toxoids will use the NDC as part of the pharmacy pricing methodology, specifically the lowest of (a) the usual and customary charge to the public or the pharmacy's actual submitted ingredient cost; (b) the National Average Drug Acquisition Cost (NADAC) established by CMS; (c) the Affordable Care Act Federal Upper Limit (FUL); or (d) Wholesale Acquisition Cost (WAC) plus zero (0) percent when no NADAC is available for a specific drug.

Fee schedules are published at this link: http://www.ctdssmap.com, then select "Provider", then select "Provider Fee Schedule Download."

Fiscal Information

DSS estimates that this SPA will result in a gross increase in Medicaid expenditures of approximately $333,000 in State Fiscal Year (SFY) 2019 and $375,000 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-V: Updates to the Physician Office and Outpatient Fee Schedule".

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 11, 2018.

(5) Physician's services – Fixed fee schedule not to exceed the Medicare physician fee schedule. The current fee schedule was set as of July 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,

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Connecticut

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