DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 19-E: Medical Clinic, Family Planning Clinic, Behavioral Health Clinic, Dialysis Clinic, Rehabilitation Clinic, and Ambulatory Surgery Center Fee Schedules – HIPAA Billing Code and Reimbursement Update

The State of Connecticut Department of Social Services (DSS) proposes to submit the following Medicaid State Plan Amendment 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 January 1, 2017, SPA 17-D will amend Attachment 4.19-B of the Medicaid State Plan to revise the Medical Clinic, Dialysis Clinic, Family Planning Clinic, Behavioral Health Clinic, Rehabilitation Clinic, and Ambulatory Surgical Center fee schedules. These revisions incorporate the 2019 Healthcare Common Procedure Coding System (HCPCS) changes (additions, deletions and description changes) to remain compliant with the Health Insurance Portability and Accountability Act (HIPAA). Codes that are being added are being priced using a comparable methodology to other codes in the same or similar category. For newly added codes that are replacing codes that are being deleted, they are being priced in a manner designed to be cost-neutral to the previous overall payment methodology.

In addition, SPA 19-E will also amend Attachment 4.19-B of the Medicaid State Plan to update the reimbursement methodology to 100% of the January 2019 Medicare Average Sales Price (ASP) Drug Pricing file for physician-administered drugs, immune globulins, vaccines and toxoids. This update applies to physician administered drugs (J- procedure codes and select A-, Q- and S- procedure codes), immune globulin (procedure codes 90281 – 90399), and vaccines and toxoids (procedure codes 90581 – 90748) that are listed as payable on each of the following fee schedules: medical clinic, family planning clinic, dialysis clinic, and free-standing behavioral health clinic. For procedure codes that are not priced on the January 2019 Medicare ASP Drug Pricing File and procedure codes that are described as "unclassified", the drug will be priced at the lowest of:

- The usual and customary charge to the public or the actual submitted ingredient cost;
- The National Average Drug Acquisition Cost (NADAC) established by CMS;
- The Affordable Care Act Federal Upper Limit (FUL); or
- Wholesale Acquisition Cost (WAC) plus zero (0) percent when no NADAC is available for the specific drug.

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

Fiscal Impact

DSS estimates that, overall, this SPA will increase annual aggregate expenditures by approximately $33,000 in State Fiscal Year (SFY) 2019 and $82,000 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 17-D: Clinics – HIPAA Compliance and Reimbursement Update".

Anyone may send DSS written comments about this SPA. Written comments must be received by DSS at the above contact information no later than January 10, 2019.

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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 January 1, 2019 and is effective for services provided on or after that date. All rates are published at www.ctdssmap.com.

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(b) Dialysis Clinics: The current fee schedule was set as of January 1, 2019 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 January 1, 2019 and is effective for services provided on or after that date. All rates are published at www.ctdssmap.com.

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(d) Medical Clinics: The current fee schedule was set as of January 1, 2019 and is effective for services provided on or after that date. All rates are published at www.ctdssmap.com. Rates are the same for private and governmental providers.

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(e) Behavioral Health Clinics:

(e.1) **Private Behavioral Health Clinics.**

The current fee schedule was set as of January 1, 2019 and is effective for services on or after that date. Fees for services provided to individuals 18 years of age and over will be 95% of the published fee.

Effective January 1, 2012 the Department established a separate fee schedule for private behavioral health clinics that meet special access and quality standards and such fees are higher than the fees available to clinics that do not meet such special standards. These clinics 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. These clinics must have at least nine (9) extended hours per week beyond routine business hours of 8:00 AM to 5:00 PM. Providers that are designated Enhanced Care Clinics and 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. All Enhanced Care Clinics must electronically register appointments made with the Administrative Services Organization (ASO)

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(f) Rehabilitation Clinics:

The current fee schedule was set as of January 1, 2019 and is effective for services provided on or after that date. All rates are published at www.ctdssmap.com.