DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 20-R: Coverage and Payment Updates to Address COVID-19 (Coronavirus)

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 March 18, 2020, SPA 20-R will amend the Medicaid State Plan as described below. This SPA will amend Attachment 4.19-B of the Medicaid State Plan to make the following payment updates, each of which is designed to respond to the COVID-19 (Coronavirus) outbreak. The Department may implement one or more of these payment changes as it determines necessary in order to respond to COVID-19.

These services are payable only to the extent that the Department has communicated them in writing to providers through the state's provider manual, including policy transmittals, provider bulletins, and other written guidance. Coverage and payment of applicable services and other procedures reflected in this SPA will end once the Department has communicated in writing that such services and procedures are no longer necessary to respond to COVID-19. The termination of the provisions in this SPA will be implemented through one or more future SPAs, to the extent necessary.

The Department is proposing this SPA in order to facilitate prompt testing for the virus when medically necessary, help reduce unnecessary exposure of health care workers and the general public, and generally help address and contain the spread of the virus.

The Department will be adding one or more of the following Healthcare Common Procedure Coding System (HCPCS) codes to various fee schedules for which the addition of the code is clinically appropriate in response to COVID-19 and when payment for such service is in accordance with applicable federal and state requirements for such category of service. One or more of the following fee schedules may be updated to include one or more of the services identified below: Independent Laboratories, Federally Qualified Health Centers, Physician Office and Outpatient, Outpatient Hospitals, and Clinics (medical, behavioral health and family planning clinics). Other fee schedules may also be identified as relevant based on additional analysis. The applicable fee schedule(s) will be updated with the codes and rates as soon as possible (as information is disseminated by the federal government), and providers will be notified via a provider bulletin outlining all of the appropriate guidance for billing and reimbursement.

- HCPCS Code U0001 – 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel, which will be payable to specified laboratory providers. This code will be priced at a fixed fee that is a percentage of the fee set by Medicare. . If Medicare does not set a fee, then the Department will set a fixed fee based on an analysis of comparable laboratory services.

- HCPCS Code U0002, which generally describes 2019-nCoVCoronavirus, SARS-CoV-2/2019-nCoV (COVID-19) using any technique, multiple types or subtypes (includes all targets), which will be payable to specified laboratory providers. This code will be priced at a fixed fee that is a percentage of the fee set by Medicare. If Medicare does not set a fee, then the Department will set a fixed fee based on an analysis of comparable laboratory services.
- HCPCS Code G0071, for payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between a federally qualified health center (FQHC) practitioner and FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an FQHC practitioner. The FQHC would receive its applicable medical or behavioral health encounter rate, medical or behavioral, for providing such services in accordance with all applicable requirements, including the limitation to only one medical encounter rate and one behavioral health encounter rate for the same person on the same date of service.
- HCPCS codes 99441-99443 Evaluation and Management (E&M) services titled "Non-Face-to-Face Services", subsection Telephone Services (codes 99441 – 99443), which will be available to one or more of the practitioners and clinic types that may bill for E&M services, which the Department anticipates may include: physicians, advance practice registered nurses (nurse practitioners), physician assistants, nurse midwives, podiatrists, naturopathic physicians (naturopaths), medical clinics, behavioral health clinics (including outpatient hospital), and family planning clinics. Each of the applicable codes will be priced at a fixed fee to be determined based on an analysis of the Department's existing fees for comparable services within the applicable category of service.
- HPCPCS Codes 99866 – 99868 - services titled "Non-Face-to-Face Services Nonphysician Services", subsection Telephone Services (codes 98966-98968), which will be available to one or more of the practitioners and clinic types that may bill for psychotherapy services, which the Department anticipates may include: medical clinics, behavioral health clinics including enhanced care clinics, rehabilitation clinics, licensed behavioral health clinicians and outpatient hospitals behavioral health clinics, outpatient psychiatric hospitals and outpatient chronic disease hospitals. Each of the applicable codes will be priced at a fixed fee to be determined based on an analysis of the Department's existing fees for comparable services within the applicable category of service.

Additional details are specified in the proposed SPA pages. Fee schedules are published at this link: http://www.ctdssmap.com, then select "Provider", then select "Provider Fee Schedule Download", then Accept or Decline the Terms and Conditions and then select the applicable fee schedule.

In addition to the proposed payment changes described above, this SPA will also amend Attachments 3.1-A and 3.1-B to make the following coverage changes for the same effective dates and purpose. Except for controlled substances, 90-day supplies of medication will be authorized for both maintenance and non-maintenance medications. The restrictions on early

refills of medications will be modified to enable earlier refills than currently allowed without authorization. In particular, refills will be permitted once a member has used 80 percent of the supply as opposed to the current threshold, which is 93 percent.

In addition, under existing state law, full benefit dually eligible Medicare Part D beneficiaries are responsible for their monthly copayments, up to an aggregate amount of seventeen dollars per month. The Department is responsible for copayment amounts that exceed seventeen dollars. Under the provisions of this amendment, the beneficiaries will no longer be responsible for these copayments for Part D drugs. The Department will assume responsibility for all copayments on behalf of such beneficiaries.

Providers should carefully review all provider bulletins and other communications from the Department, including any guidance regarding the relevant coverage and payment for services and any guidance regarding the coverage of specified telemedicine services. The Department will publish additional public notices as necessary if additional payment changes are necessary to facilitate providers' response to COVID-19.

Fiscal Impact

Based on the current available information, DSS estimates that this SPA will increase annual aggregate expenditures by amounts to be determined. Adding the specified laboratory testing codes is likely to increase expenditures in amounts to be determined after pricing information and other data becomes available. At this time, it is not possible to determine whether code G0071 and the telephonic evaluation and management codes and other telephonic codes will increase annual aggregate expenditures because those codes may be billed in lieu of billing for in-person visits that would otherwise have occurred, but they may also result in increased expenditures. The changes to pharmacy authorization procedures may also result in additional expenditures in amounts to be determined.

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 20-R: Coverage and Payment Updates to Address COVID-19 (Coronavirus)".

Anyone may send DSS written comments about this SPA. Written comments must be received by DSS at the above contact information no later than March 31, 2020.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: CONNECTICUT

Coverage Updates Designed to Assist Providers in Responding to COVID-19 (Coronavirus)

Notwithstanding any other provisions of the Medicaid State Plan to the contrary, effective from March 18, 2020, coverage is authorized for the following services, which the Department of Social Services has determined are designed to respond to the outbreak of the COVID-19 (Coronavirus) and the related public health emergency. These coverage changes are being made within the benefit categories within section 1905(a) of the Social Security Act listed below. The Department plans to submit a new Medicaid State Plan Amendment (SPA) to end-date payment for these services after the Department has determined that the outbreak has concluded and/or that there is no longer a public health emergency. The Department has communicated additional details regarding these services in its provider manual.

1. Pharmacy – 90-Day Supply (section 1905(a)(12) - outpatient prescription drugs): The Department will authorize a 90-day supply of medication other than controlled substance medications.

2. Pharmacy – Early Refills (section 1905(a)(12) - outpatient prescription drugs): The Department will relax the early refill policy by decreasing the percentage needed to be used before a prescription can be refilled to 80% of the prescription.

3. Telemedicine: Telemedicine is authorized to the extent specified by the Department in its provider manual.

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4. Pharmacy – 90-Day Supply (section 1905(a)(12) - outpatient prescription drugs): The Department will authorize a 90-day supply of medication other than controlled substance medications.

5. Pharmacy – Early Refills (section 1905(a)(12) - outpatient prescription drugs): The Department will relax the early refill policy by decreasing the percentage needed to be used before a prescription can be refilled to 80% of the prescription.

6. Telemedicine: Telemedicine is authorized to the extent specified by the Department in its provider manual.

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Each of the applicable current fee schedules was set as of March 18, 2020 and is effective for services provided on or after that date. Each fee schedule 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.

1. Laboratory Tests (section 1905(a)(3) – Laboratory Services): Health Care Common Procedural Coding System (HCPCS) codes U0001 and U0002 are being added to the laboratory fee schedule.

2. Telephone Services (sections 1905(a)(5), (6), (9) – Physician, Other Licensed Practitioner, Clinic Services): Current Procedural Terminology (CPT) codes in the Evaluation and Management (E&M) section titled "Non-Face-to-Face Services", subsection Telephone Services (codes 99441 – 99443) are being added to the physician office and outpatient and the applicable clinic fee schedules, which can be billed, as applicable by, physicians, advance practice registered nurses (nurse practitioners), physician assistants, nurse midwives, podiatrists, naturopathic physicians (naturopaths), medical clinics, rehabilitation clinics, and family planning clinics.

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Payment Updates Designed to Assist Providers in Responding to COVID-19 (Coronavirus) (cont'd)

3. Virtual Communication and Remote Evaluation in Lieu of Office Visit (section 1905(a)(2) – Federally Qualified Health Center [FQHC] Services): An FQHC may receive its applicable medical encounter rate for services that meet the definition of HCPCS Codes G0071 – for payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between a federally qualified health center (FQHC) practitioner and FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an FQHC practitioner, occurring in lieu of an office visit. This payment is subject to all applicable requirements, including that an FQHC may receive only one medical encounter rate for the same person on the same date of service.