DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 20-V: COVID-19 Coverage and Payment Updates After Federal Public Health Emergency

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 25, 2020, SPA 20-V will amend Attachments 3.1-A, 3.1-B, 4.19-B, and 4.19-D of the Medicaid State Plan as described below.

The purpose of this SPA is to continue Medicaid coverage and payment for certain services related to the state's response to the Coronavirus Disease 2019 (COVID-19) pandemic that have been included in CT SPA 20-0015: COVID-19 Disaster Relief, which is the state's Medicaid disaster relief SPA for COVID-19. As a disaster relief SPA, 20-0015 will automatically end-date after the end of the federally declared public health emergency (PHE), including any extensions, so this SPA is necessary to continue certain changes after the end of the federal PHE. At the time this notice is being submitted for publication, the last day of the federal PHE is scheduled to be July 24, 2020. Although the federal government may renew the PHE declaration, at the time federal regulations require public notice to be published, it is not yet known if the federal PHE will be renewed. If the federal PHE is renewed, it is anticipated that the effective date of this SPA may be delayed until after the end of the federally declared PHE. For some of these, as specified below, the change will expire at the end of the state declared PHE, including any extensions. 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.

Telehealth Coverage and Payment

New telehealth coverage pages will be added to Attachments 3.1-A and 3.1-B to provide that DSS covers telehealth to the extent authorized in its provider manual. Technical changes to existing SPA pages will also be made to remove any language that would otherwise prohibit telehealth coverage.

Effective through the end of the state PHE, Attachment 4.19-B will be amended to reflect that specific codes have been added to the physician and applicable clinic fee schedules to enable audio-only evaluation and management services to be provided by the following categories of providers: physician, physician assistants, advance practice registered nurses (APRNs), certified nurse-midwives, free-standing medical clinics, behavioral health clinics (including enhanced care clinics), outpatient hospital behavioral health clinics, public and private psychiatric outpatient hospital clinics, and family planning clinics fee schedules and may be billed by the providers as specified in the state's provider manual. These codes were set in a manner designed to approximate similar rates for equivalent in-person services, while accounting for differences in the time parameters associated with the in-person and audio-only codes.

Effective through the end of the state PHE, to the extent necessary and to the extent possible within available coding options, Attachment 4.19-B will be amended to enable audio-only psychotherapy to be provided by the following categories of providers: independent licensed behavioral health clinicians (licensed psychologists, licensed clinical social workers (LCSWs), licensed marital and family therapists (LMFTs), licensed professional counselors (LPCs), and licensed alcohol and drug counselors (LADCs)), behavioral health clinics (including enhanced care clinics), outpatient hospital behavioral health clinics, public and private psychiatric outpatient hospital clinics, free-standing medical clinics, rehabilitation clinics, behavioral health FQHCs, physicians, advanced practice registered nurses, and physician assistants. To the extent possible, these codes will be paid at the same rates as equivalent in-person services.

Laboratory Services Coverage and Payment

The laboratory coverage language in Attachments 3.1-A and 3.1-B will be updated to include the state's selection pursuant to 42 CF.R. 440.30(d), to cover laboratory tests (including self-collected tests authorized by the FDA for home use) to diagnose or detect SARS-CoV-2, antibodies to SARS-CoV-2, or COVID-19 or the communicable disease named in the federal Public Health Emergency (PHE) as defined in 42 CFR 440.30(d) or its causes that do not meet one or more conditions specified in 42 CFR 440.30(a) and (b), because such coverage flexibility is intended to avoid transmission of COVID-19 or such other communicable disease. This coverage applies for the duration of any applicable Public Health Emergency and continues during any subsequent period of active surveillance, each as defined in 42 CFR 440.30(d).

In addition, Attachment 4.19-B will be amended to reflect that the laboratory (lab), medical clinic (MC), dialysis clinic (DC), and family planning clinic (FPC) fee schedules will be updated to add payment for specified codes related to testing of COVID-19 that have been added to the Medicare fee schedule. DSS anticipates continuing to have the following Healthcare Common Procedural Coding System (HCPCS) codes on the applicable fee schedules:

Laboratory Fee Schedule:

HCPCS Codes 87635, 86328, 86769, U0003, U0004, U0001, U0002, and 87426.

Clinic Fee Schedules:

HCPCS Code	**Fee Schedule(s)**
87635	DC, MC, FPC
U0001	DC, MC, FPC
U0002	DC, MC, FPC
U0003	FPC

From the end of the federally declared PHE until the end of the state declared PHE, these codes will be paid at 100% of the 2020 Medicare rate. After the state PHE ends, consistent with the reimbursement of other codes on the applicable fee schedule, the reimbursement methodology for the specified codes related to COVID-19 testing will be updated as follows: lab fee schedule will be paid at 70% of Medicare; MC and FPC fee schedules will be paid at 80% of Medicare; and DC fee schedule will be paid at 100% of Medicare.

Relaxing Requirements for Enhanced Care Clinics

Effective through the end of the state PHE, Attachment 4.19-B will be amended to reflect that the following requirements for the Enhanced Care Clinic higher payment rate for behavioral health clinics have been relaxed (no change in the rates, only relaxing the requirements for the provider to be eligible to receive the applicable rates):

i. Suspending all specific time requirements for urgent or emergent cases;
ii. Allowing clinics to temporarily merge sites to consolidate staff due to staffing shortages;
iii. Suspending the state's Mystery Shopper calls; and
iv. Waiving the requirement for extended operating hours.

Payment Changes to Accommodate Addition of Agency-Based PCA and Shelf-Stable Meals, and Emergency Meal Delivery Within the Community First Choice (CFC) Program Pursuant to Section 1915(k) of the Social Security Act and Other CFC Payment Changes

Effective through the end of the state PHE, Attachment 4.19-B will be amended to reflect that the payment methodology for CFC is modified as follows:

The state adds payment for agency-based PCAs as follows based on a fee schedule (no changes to the payment methodology for self-directed PCAs). The fee schedule is as follows:

Personal Care Services: Overnight Per Diem (12 Hour) Shift Agency: $180.63
Personal Care Services: Per Diem (24 Hour) Agency: $243.61
PCA Agency Per Diem Prorated Hourly: $10.15
PCA Agency Overnight Prorated Hourly: $15.05
PCA Agency 15 minute: $4.92

Shelf-Stable Meals: Shelf-stable meals are paid at the following rates:

Meal Service Single Shelf-Stable Meal: $6.50
Meal Service Double Shelf-Stable Meal: $13.50
Kosher Meal Double Shelf-Stable Meal: $13.50

Emergency meal delivery: Flat pick up rate of $8.50 and $1.75 per mile thereafter allocated equally across all participants receiving meals.

Nurse Health Coach: In order to maintain compliance with the Health Insurance Portability and Accountability Act (HIPAA), the following code is added to ensure continuity of coverage to replace a code that was removed from the Healthcare Common Procedural Coding System (HCPCS) national billing code set:

Registered Nurse Health Coach (HCPCS Code S5108): Max fee of $23.80 per 15 minutes

Relaxing Requirement for Payment to Private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Individual Leave Days

Effective through the end of the state PHE, Attachment 4.19-D is amended to reflect that individuals residing at the ICF/IID may exceed the standard home and hospital leave days and the state will pay the ICF/IID for those days without limit during the public health emergency. This change is necessary to ensure the ICF/IID is able to maintain their beds for when the individuals are able to return to the facility at the end of the public health emergency as well as facilitating individuals taking home leave in order to reduce the risk of COVID-19 spreading among the facility residents and staff.

Random Moment Time Study (RMTS)/Time Study Flexibility

In certain situations in which the Medicaid State Plan provides for the use of RMTS in allocating costs for providers paid using a cost-based payment methodology, Attachment 4.19-B is amended to reflect the following flexibilities during the PHE to the extent that the state determines that such flexibility is necessary in order to appropriately reflect the disruptions in

staffing, operations, and impact on members during the COVID-19 pandemic, including, as necessary, use of the RMTS average quarter results for the quarters ending December 31, 2020, March 31, 2021, and/or June 30, 2021, or such other quarter(s) as determined by the state, in place of the RMTS results for the quarter ending September 30, 2020 and any other applicable quarter(s) determined by the state. This flexibility applies to all such programs with RMTS in the Medicaid State Plan, including, but not limited to: behavioral health homes pursuant to section 1945 of the Social Security Act, targeted case management for individuals with chronic mental illness (TCM-CMI), Department of Mental Health and Addiction Services' publicly operated behavioral health clinics and outpatient hospitals, and TCM for individuals with intellectual disabilities (TCM-IID).

For private non-medical institution services (PNMI) for adults, the state plan will be modified to require only one time study in PNMI for adults, where two time studies are otherwise required each SFY.

Additionally, for the School Based Child Health program, the state plan will be modified to increase the oversample in developing the statistically valid sample size due to COVID-19 related issues in schools for the 2nd quarter of SFY 2021 and any other calendar quarter(s) determined by the state.

Fiscal Impact

In general, DSS does not anticipate that this SPA will substantially change annual aggregate expenditures because these changes are broadly intended to enable continuity of coverage and payment during COVID-19 for services that would otherwise have been performed in accordance with parameters that were in effect prior to the PHE, as applicable. For the COVID-19 laboratory testing services, compared to the general Medicaid State Plan in effect prior to the PHE, based on information that is available at this time and subject to change in utilization over time, DSS estimates that those services will increase annual aggregate expenditures by approximately $1.5 million.

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-V: COVID-19 Coverage and Payment Updates After Federal Public Health Emergency".

Anyone may send DSS written comments about this SPA. Written comments must be received by DSS at the above contact information no later than August 5, 2020.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
CATEGORICALLY NEEDY GROUP(S): ALL
State: CONNECTICUT

3. Laboratory and X-Ray Services (continued)

Coverage Flexibility for Laboratory Services (Location and Practitioner Order): Pursuant to 42 CFR 440.30(d), the state covers laboratory tests (including self-collected tests authorized by the FDA for home use) to diagnose or detect SARS-CoV-2, antibodies to SARS-CoV-2, or COVID-19 or the communicable disease named in the Public Health Emergency as defined in 42 CFR 440.30(d) or its causes that do not meet one or more conditions specified in 42 CFR 440.30(a) and (b), because such coverage flexibility is intended to avoid transmission of COVID-19 or such other communicable disease. This coverage applies for the duration of any applicable Public Health Emergency and continues during any subsequent period of active surveillance, each as defined in 42 CFR 440.30(d).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
CATEGORICALLY NEEDY GROUP(S): ALL
State: CONNECTICUT

Coverage of Telemedicine

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
CATEGORICALLY NEEDY GROUP(S): ALL
State: CONNECTICUT

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a. The Department will not pay for any immunizations, biological products and other products available to physicians free of charge from the Connecticut State Department of Public Health ~~Services~~.

b. The Department will not pay for any examinations and laboratory tests for preventable diseases which are furnished free of charge by the Connecticut State Department of Public Health ~~Services~~.

~~c. The Department will not pay for information provided by a physician over the telephone.~~

~~d.~~c. The Department will not pay for cosmetic surgery.

~~e.~~d. The Department will not pay for an office visit for the sole purpose of the patient obtaining a prescription where the need for the prescription has already been determined.

~~f.~~e. The Department will not pay for cancelled office visits or for appointments not kept.

~~g.~~f. Services are limited to those listed in the Department's fee schedule.

~~h.~~g. No more than one (1) psychiatric evaluation in any twelve (12) month period per provider for the same recipient.

~~i.~~h. No more than one (1) psychiatric therapy visit of the same type per day.

~~j.~~i. No more than eight (8) persons per psychiatric group therapy session.

~~k.~~j. Payment will be denied for physicians' services to general hospital recipients if the Department determines that the medical care, treatment or service does not or did not meet the established medically necessary and/or utilization review standard in accordance with generally accepted criteria and standards of medical practice, or if they do not or did not comply with the other policies, procedures, conditions and limitations established by the Department. This determination may be made at the time of prior authorization, preadmission review, or retrospective review. The fact that a denial was not made at an earlier stage shall not preclude such a determination at a later stage. The Department is entitled to disallow the entirety or any portion of the stay and services provided they do not meet the medically necessary or utilization review standard.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL
State: CONNECTICUT

3. Laboratory and X-Ray Services (continued)

Coverage Flexibility for Laboratory Services (Location and Practitioner Order): Pursuant to 42 CFR 440.30(d), the state covers laboratory tests (including self-collected tests authorized by the FDA for home use) to diagnose or detect SARS-CoV-2, antibodies to SARS-CoV-2, or COVID-19 or the communicable disease named in the Public Health Emergency as defined in 42 CFR 440.30(d) or its causes that do not meet one or more conditions specified in 42 CFR 440.30(a) and (b), because such coverage flexibility is intended to avoid transmission of COVID-19 or such other communicable disease. This coverage applies for the duration of any applicable Public Health Emergency and continues during any subsequent period of active surveillance, each as defined in 42 CFR 440.30(d).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL
State: CONNECTICUT

Coverage of Telemedicine

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL
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~~c. The Department will not pay for information provided by a physician over the telephone.~~

~~d.~~c. The Department will not pay for cosmetic surgery.

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~~f.~~e. The Department will not pay for cancelled office visits or for appointments not kept.

~~g.~~f. Services are limited to those listed in the Department's fee schedule.

~~h.~~g. No more than one (1) psychiatric evaluation in any twelve (12) month period per provider for the same recipient.

~~i.~~h. No more than one (1) psychiatric therapy visit of the same type per day.

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

(3) Other Laboratory and X-ray Services –The fee schedules and any adjustments to the fee schedules are published in www.ctdssmap.com. Fees are effective as of the date noted below, except that fees may be deleted or added and priced in order to remain compliant with HIPAA or to correct pricing errors. Laboratory and X-ray service fees are the same for both governmental and private providers.

- Laboratory Services were set as of ~~January 1~~July 25, 2020. The Department reviews Medicare rate changes annually to ensure compliance with federal requirements.
- X-ray services provided by independent radiology centers were set as of January 1, 2020. Select the "Independent Radiology" fee schedule, which displays global fees, including both the technical and professional components of each fee.

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

(b) Dialysis Clinics: The current fee schedule was set as of ~~January 1, 2019~~July 25, 2020 and is effective for services provided on or after that date. All rates are published at www.ctdssmap.com.

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

(c) Family Planning Clinics: The current fee schedule was set as of ~~January 1~~July 25, 2020 and is effective for services provided on or after that date. All rates are published at www.ctdssmap.com.

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

(d) Medical Clinics: The current fee schedule was set as of ~~January 1~~July 25, 2020 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.

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

Temporary Payment Changes Related to the State's Response to the Coronavirus Disease 2019 (COVID-19) Pandemic After the Federal Public Health Emergency (PHE)

1. Relaxing Requirements for Enhanced Care Clinics (Sections 1902(a)(2) and 1902(a)(9) – Outpatient Hospital and Clinic Services)

Effective through the end of the state PHE, notwithstanding other provisions of Attachment 4.19-B that would otherwise apply, the following requirements for the Enhanced Care Clinic higher payment rate for behavioral health clinics are relaxed (no change in the rates, only relaxing the requirements for the provider to be eligible to receive the applicable rates):

i. Suspending all specific time requirements for urgent or emergent cases;
ii. Allowing clinics to temporarily merge sites to consolidate staff due to staffing shortages;
iii. Suspending the state's Mystery Shopper calls; and
iv. Waiving the requirement for extended operating hours.

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

Temporary Payment Changes Related to the State's Response to the Coronavirus Disease 2019 (COVID-19) Pandemic After the Federal Public Health Emergency (PHE) (cont'd)

2. Payment Changes to Accommodate Addition of Agency-Based PCA and Shelf-Stable Meals, and Emergency Meal Delivery Within the Community First Choice (CFC) Program Pursuant to Section 1915(k) of the Social Security Act and Other CFC Payment Changes

Effective through the end of the state PHE, notwithstanding other provisions of Attachment 4.19-B that would otherwise apply, effective through the end of the state PHE, the payment methodology for CFC is modified as follows:

Agency-Based PCAs: The state adds payment for agency-based PCAs as follows based on a fee schedule (no changes to the payment methodology for self-directed PCAs). The fee schedule is as follows:

Personal Care Services: Overnight Per Diem (12 Hour) Shift Agency: $180.63
Personal Care Services: Per Diem (24 Hour) Agency: $243.61
PCA Agency Per Diem Prorated Hourly: $10.15
PCA Agency Overnight Prorated Hourly: $15.05
PCA Agency 15 minute: $4.92

Shelf-Stable Meals: Shelf-stable meals are paid at the following rates:

Meal Service Single Shelf-Stable Meal: $6.50
Meal Service Double Shelf-Stable Meal: $13.50
Kosher Meal Double Shelf-Stable Meal: $13.50

Emergency Meal Delivery: Flat pick up rate of $8.50 and $1.75 per mile thereafter allocated equally across all participants receiving meals.

Nurse Health Coach: In order to maintain compliance with the Health Insurance Portability and Accountability Act (HIPAA), the following code is added to ensure continuity of coverage to replace a code that was removed from the Healthcare Common Procedural Coding System (HCPCS) national billing code set:

Registered Nurse Health Coach (HCPCS Code S5108): Max fee of $23.80 per 15 minutes

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

Temporary Payment Changes Related to the State's Response to the Coronavirus Disease 2019 (COVID-19) Pandemic After the Federal Public Health Emergency (PHE) (cont'd)

3. Random Moment Time Study (RMTS) / Time Study Flexibility (Sections 1902(a)(2), (4), (9), (13), (19), and 1945 – Outpatient Hospital, EPSDT, Clinic, Rehabilitation, Targeted Case Management, and Health Home Services)

In certain situations in which the Medicaid State Plan provides for the use of RMTS in allocating costs for providers paid using a cost-based payment methodology, notwithstanding other provisions of Attachment 4.19-B that would otherwise apply, the following flexibilities are added to the extent that the state determines that such flexibility is necessary in order to appropriately reflect the disruptions in staffing, operations, and impact on members during the COVID-19 pandemic. These flexibilities will continue through the end of the state PHE or the end of the State Fiscal Year or calendar quarter that occurs after the end of the state PHE, whichever is applicable, including:

a. As necessary, use of the RMTS average quarter results for the quarters ending December 31, 2020, March 31, 2021, and/or June 30, 2021, or such other quarter(s) as determined by the state, in place of the RMTS results for the quarter ending September 30, 2020 and any other applicable quarter(s) determined by the state. This flexibility applies to all such programs with RMTS in the Medicaid State Plan, including, but not limited to: behavioral health homes pursuant to section 1945 of the Social Security Act, targeted case management for individuals with chronic mental illness (TCM-CMI), Department of Mental Health and Addiction Services' publicly operated behavioral health clinics and outpatient hospitals, and TCM for individuals with intellectual disabilities (TCM-IID).

b. For private non-medical institution services (PNMI) for adults (under the rehabilitation services benefit category), only one time study is required for PNMIs for adults for the State Fiscal Year (SFY), where two time studies would otherwise be required each SFY.

c. For the School Based Child Health program (under the EPSDT benefit category), the state plan will be modified to increase the oversample in developing the statistically valid sample size due to COVID-19 related issues in schools for the 2nd quarter of SFY 2021 and any other calendar quarter(s) determined by the state.

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

Temporary Payment Changes Related to the State's Response to the Coronavirus Disease 2019 (COVID-19) Pandemic After the Federal Public Health Emergency (PHE) (cont'd)

Relaxing Requirement for Payment to Private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Individual Leave Days

Effective through the end of the state PHE, notwithstanding other provisions of Attachment 4.19-D that would otherwise apply, individuals residing at the ICF/IID may exceed the standard home and hospital leave days and the state will pay the ICF/IID for those days without limit during the public health emergency. This change is necessary to ensure the ICF/IID is able to maintain their beds for when the individuals are able to return to the facility at the end of the public health emergency as well as facilitating individuals taking home leave in order to reduce the risk of COVID-19 spreading among the facility residents and staff.