DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 21-B: Physician Services – Updates for HIPAA Billing Code Compliance, Physician-Administered Drugs, and Person-Centered Medical Home Program (PCMH) Billing Codes for Fee-for-Service Add-On and Quality Measures for PCMH Performance Payments

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 January 1, 2021, SPA 21-B will amend Attachment 4.19-B of the Medicaid State Plan to make the updates to the payment for physician services described below.

First, this SPA will incorporate various 2021 federal Healthcare Common Procedural Coding System (HCPCS) updates (additions, deletions and description changes) to the Physician Office & Outpatient, Physician-Radiology, and Physician-Surgery fee schedules. Codes that are being added are being priced using a comparable methodology to other codes in the same or similar category. DSS is making these changes to ensure that these fee schedules remain compliant with the Health Insurance Portability and Accountability Act (HIPAA).

Second, in accordance with the existing federally approved methodology for physician-administered drugs in the Medicaid State Plan, this SPA will update the reimbursement methodology to 100% of the January 2021 Medicare Average Sales Price (ASP) Drug Pricing file for physician-administered drugs, immune globulins, vaccines and toxoids.

For procedure codes that are not priced on the January 2021 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."

Finally, this SPA will also make the following technical updates to the PCMH program. As part of the federal HCPCS update referenced above, the definitions of two of the codes previously eligible for the PCMH fee-for-service add-on payment were revised so that they will no longer be able to be billed in the context of evaluation and management (E&M) services (Current Procedural Terminology [CPT] codes 99354 and 99355). Therefore, those codes will be removed from the list of codes eligible for the PCMH fee-for-service add-on. DSS intends to replace those codes on the list of those eligible for the PCMH fee-for-service add-on with CPT code 99417, to be priced in a manner that is designed to be cost-neutral to the prior level for CPT codes 99354 and 99355.

In addition, the quality measures for PCMH, which are used in calculating the PCMH supplemental payments for performance and improvement and the challenge pool supplemental payment, will be updated in order to reflect various changes to the measures by the applicable measure stewards. These changes include removing quality measures that have been retired, incorporating changes to the measures that have been made by the measure stewards, and updating measures to new stewards as appropriate. This SPA may also include further adjustments to the methodology for the performance payments to account for disruptions in utilization patterns due to the Coronavirus Disease 2019 (COVID-19) pandemic and associated public health emergency declarations.

Fiscal Impact

DSS estimates that the HIPAA compliance changes will increase annual aggregate expenditures for physician office and outpatient by approximately $7,800 in State Fiscal Year (SFY), 2021 $20,000 in SFY 2022 and $20,300 in SFY 2023; physician surgery by approximately $23,800 in State Fiscal Year (SFY) 2021, $60,500 in SFY 2022 and $62,300 in SFY 2022; and physician radiology by approximately $1,500 in State Fiscal Year (SFY) 2021, $3,700 in SFY 2022 and $3,800 in SFY 2023. DSS estimates that updating the physician-administered drugs to the January 2021 Medicare ASP Drug Pricing File, as required by the existing approved Medicaid State Plan payment methodology for physician-administered drugs, will increase annual aggregate expenditures by approximately $210,000 in SFY 2021 and $520,000 in SFY 2022. DSS does not anticipate that the PCMH updates will have any significant changes in annual aggregate expenditures.

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. Please reference "SPA 21-B: Physician Services – Updates for HIPAA Billing Code Compliance, Physician-Administered Drugs, and Person-Centered Medical Home Program (PCMH) Billing Codes for Fee-for-Service Add-On and Quality Measures for Performance Payments".

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 13, 2021.

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(5) Physician's services – Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of physician's services. The agency's fee schedule rates were set as of ~~December 1, 2020~~January 1, 2021 and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the applicable 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, 99417, 99374, 99377, 99379, 99380, 96110, 99050, 99051, 99053, D0145,

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(c) Quality Performance Measures for PCMH Program. The department's quality performance measures for the PCMH program are updated as of January 1, 2021 and are effective for measurement of quality performance and for quality payments made on or after that date. The quality performance measures can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. Select "Information", then select "Publications", then scroll down to the section regarding the PCMH program. The quality measures are used to measure PCMH practices' performance and their eligibility for certain payments that are described in the relevant section of the plan as being made or determined using these quality measures. These quality measures are based on improving quality, access, and care outcomes.

PCMH Quality Measure Set for MY2020 (applicable for payments issued in CY 2021 forward)

Pediatric Measures	Measure Steward	National Quality Foundation #
Asthma Patients with One or More Asthma-Related Emergency Room Visit(s) (Ages 2-20)	DSS	NA
Behavioral Health Screening 1–18	DSS	NA
Developmental Screening in the First Three Years of Life	CMS	NA
Immunizations for Adolescents - HPV	NCQA	1407
Child and Adolescent Well-Care Visits (Combined Rate of 12-17 and 18-21 for comparison to MY2019 AWC measure) (WCV)	NCQA	1516
Adult Measures		
Breast Cancer Screening (BCS)	NCQA	2372
Chlamydia Screening in Women (CHL)	NCQA	0033
Comprehensive Diabetes Care - Hemoglobin A1c (HbA1c) testing (CDC)	NCQA	0057
Post-Admission Follow-Up Within Seven Days of an Inpatient Discharge	DSS	NA
Use of Imaging Studies for Low Back Pain (LBP)	NCQA	0052
Challenge Measures		
Behavioral Health Screening 1–18	DSS	NA
Comprehensive Diabetes Care - Eye Exam (Retinal) Performed	NCQA	0055