DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 22-H: Updates to Alternative Benefit Plan (ABP) for the Medicaid Coverage Group for Low-Income Adults to Add Mandatory Medicaid Coverage of Routine Patient Costs Furnished in Connection with Participation in Qualifying Clinical Trials

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), which will amend the Alternative Benefit Plan (ABP) at Attachment 3.1-L of the Medicaid State Plan.

The ABP is the benefit package that is provided to the Medicaid low-income adult population under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (also known as HUSKY D). Pursuant to section 2001 of the Affordable Care Act, effective January 1, 2014, Connecticut expanded Medicaid eligibility to low-income adults with incomes up to and including 133% of the federal poverty level. The expanded coverage group is referred to as Medicaid Coverage for the Lowest-Income Populations.

Changes to Medicaid State Plan

Effective on or after January 1, 2022, SPA 22-H will amend the ABP (Attachment 3.1-L of the Medicaid State Plan) in order to add coverage for the federally required coverage of routine patient costs provided to Medicaid members participating in qualifying clinical trials.

Specifically, effective for items or services furnished on or after January 1, 2022, federal law in Division CC, Title II, Section 210 of the Consolidated Appropriations Act, 2021 (Public Law 116-260) (section 210) amended sections 1905(a)(10)(A) and 1937(b)(5) of the Social Security Act to make coverage of this new benefit mandatory under the Medicaid State Plan and any benchmark or benchmark equivalent coverage also referred to as alternative benefit plans, or ABPs with respect to items and services furnished on or after January 1, 2022.

This SPA corresponds to SPA 22-F, which adds this benefit category to the underlying Medicaid State Plan (Attachments 3.1-A, 3.1-B, and 4.19-B).

As set forth in the federal law referenced above and as further detailed in the CMS State Medicaid Director Letter (SMD) # 21-005 dated December 7, 2021, this new benefit within the ABP includes only routine patient costs as defined in that federal law that would otherwise be covered under the Medicaid State Plan, waiver, or demonstration waiver under section 1115 of the Act and do not

include any investigational item or service that is the subject of the qualifying clinical trial and not otherwise covered under the state plan, waiver, or demonstration waiver. This coverage category also applies only to qualifying clinical trials that meet the specifications set forth in the federal law referenced above. Given that the federal requirements provide only for coverage and payment for otherwise covered services, this SPA will specify that the services covered will remain the same as the underlying services. Therefore, DSS does not anticipate any substantive change in coverage, nor does DSS anticipate that this SPA will change Medicaid expenditures.

This SPA will not make any other changes to the ABP than as described above, which will continue to reflect the same coverage in the ABP for HUSKY D Medicaid members as in the underlying Medicaid State Plan. Accordingly, the ABP will continue to provide full access to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to beneficiaries under age twenty-one. This includes informing them that EPSDT services are available and of the need for age-appropriate immunizations. The ABP also provides or arranges for the provision of screening services for all children and for corrective treatment as determined by child health screenings. These EPSDT services are provided by the DSS fee-for-service provider network. EPSDT clients are also able to receive any additional health care services that are coverable under the Medicaid program and found to be medically necessary to treat, correct or reduce illnesses and conditions discovered regardless of whether the service is covered in Connecticut's Medicaid State Plan.

Likewise, this SPA will not make any changes to cost sharing for the services provided under the ABP. Connecticut does not currently impose cost sharing on Medicaid beneficiaries. Because there are no Medicaid cost sharing requirements for Connecticut beneficiaries, no exemptions are necessary in order to comply with the cost sharing protections for Native Americans found in section 5006(e) of the American Recovery and Reinvestment Act of 2009.

Fiscal Impact

DSS estimates this SPA will not change annual aggregate expenditures in Federal Fiscal Year (FFY) 2022 and FFY 2023.

Obtaining SPA Language and Submitting Comments

The proposed SPA is posted on the DSS website at this link: https://portal.ct.gov/DSS/Health-And-Home-Care/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 22-H: Updates to Alternative Benefit Plan (ABP) for the Medicaid Coverage Group for Low-Income Adults Regarding Mandatory Medicaid Coverage of Routine Patient Costs Furnished in Connection with Participation in Qualifying Clinical Trials."

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 27, 2022.

Alternative Benefit Plan

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Remove

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

See Attachment 3.1-A of the Medicaid State Plan for details. No authorization requirements.

Other 1937 Benefit Provided:

Other Licensed Practitioner: Chiropractor Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Scope limited pursuant to 42 CFR 440.60(b). See Attachment 3.1-A of the Medicaid State Plan for details.

Other:

See Attachment 3.1-A of the Medicaid State Plan for details.

Other 1937 Benefit Provided:

Routine Svcs Assocd w Participation Clinical Trial

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

See section 30 of Attachment 3.1-A

Duration Limit:

See section 30 of Attachment 3.1-A

Scope Limit:

Scope limited pursuant to sections 1905(a)(30), 1905(gg), and 1937(b)(5). See section 30 of Attachment 3.1-A of the Medicaid State Plan.

Other:

Effective January 1, 2022, Routine Patient Services Associated with Participation in Qualifying Clinical Trials is added as a mandatory benefit under the ABP pursuant to section 1937(b)(5) of the Act and is detailed in sections 1905(a)(30) and 1905(gg) of the Act. All authorization, provider qualifications, amount limits, duration limits, and scope limits are the same as set forth in section 30 of Attachment 3.1-A. In

particular, as set forth in that section of Attachment 3.1-A, except as otherwise specifically provided by sections 1905(a)(30) and 1905(gg), all services provided under this benefit follow the same provisions, requirements, and limitations set forth in the applicable section of Attachment 3.1-A of the Medicaid State Plan (or, to the extent applicable, in the relevant waiver or demonstration project) that governs each applicable underlying service that is otherwise covered under the state plan, waiver, or demonstration project.

Remove

Add