**DEPARTMENT OF SOCIAL SERVICES**

**Notice of Proposed Medicaid State Plan Amendment (SPA)**

**SPA 23-G: Clinic Services – HIPAA Compliance Billing Code and Reimbursement Updates and Rate Increase for Children’s Behavioral Health Home-Based Rehabilitation Services**

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, 2023, SPA 23-G will amend Attachment 4.19-B of the Medicaid State Plan to revise various clinic fee schedules as detailed below.

First, this SPA updates the Dialysis Clinic and Ambulatory Surgical Center fee schedules to incorporate the 2023 Healthcare Common Procedural 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.

Second, this update adds standardized cognitive performance testing (code 96125) and several procedure codes for cochlear implant analysis, programming and reprogramming services (codes 92626, 92627, 92601 through 92604) will be added to the Rehabilitation Clinic fee schedule, which are paid at 95% of 2023 Medicare rates, consistent with the overall reimbursement methodology for codes on that fee schedule. The purpose of adding the standardized cognitive performance testing code is to enable appropriate reimbursement for a key component of existing covered cognitive therapy services. The purpose of adding the cochlear implant analysis, programming and reprogramming services codes is to enable access to those services in the rehabilitation clinic setting and thereby improve overall access to these services.

Third, effective for the dates of service January 1, 2023 and forward, the Department will be adding two Pneumococcal conjugate vaccine procedure codes (90671 and 90677) to the Dialysis Clinic fee schedule, not part of the HIPAA compliance update, which are set in accordance with the physician-administered drug reimbursement methodology described below. The purpose of this change is to provide access to medically necessary vaccinations services for HUSKY Health members in the dialysis clinic setting.

Fourth, effective for dates of service on or after January 1, 2023 and pending CMS approval, in accordance with state law in section 59 of Public Act 22-47, the following Psychiatric Collaborative Care Model (CoCM) procedures codes will be added to the medical clinic fee schedule (which is also the fee schedule used for medical clinics enrolled as School Based Health Centers). CoCM includes two components: (1) a primary care or other non-psychiatric treating physician, advanced practice registered nurse (APRN), physician assistant (PA) or nurse-midwife (“treating practitioner”) consulting with a qualified psychiatrist, psychiatric APRN, or psychiatric PA (“psychiatric consultant”) regarding a patient’s care and (2) structured care management performed by a qualified behavioral health care manager working under the direction of the treating practitioner and also in consultation with a psychiatric consultant, as appropriate for the specific benefit of a patient, which includes regular assessments of clinical status by using validated scales, assessing treatment adherence, and delivering brief evidence-based psychosocial interventions and may include pharmacotherapy and psychotherapy. Specifically, the following codes are being added to the above-referenced fee schedule.

|  |  |  |
| --- | --- | --- |
| **Procedure Code** | **Description** | **Rate** |
| 99492 | Initial psychiatric collaborative care management, first 70 minutes in the first calendar month | $165.47 |
| 99493 | Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month | $159.56 |
| 99494 | Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month | $68.44 |
| G2214 | Initial psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities | $66.64 |

The purpose of adding these CoCM codes to the above-referenced fee schedule is to implement the state law referenced above and to improve the coordination and quality of services provided to Medicaid members, especially regarding the coordination of behavioral health needs into primary care and other medical services.

Fifth, in accordance with the existing federally approved methodology for physician-administered drugs in the Medicaid State Plan, this SPA will update the reimbursement methodology for various physician-administered drugs as detailed below. The purpose of these changes is to align with this federally required and approved methodology. For all applicable drugs, the rates will be updated to 100% of the January 2023 Medicare Average Sales Price (ASP) Drug Pricing file for physician-administered drugs, immune globulins, vaccines, and toxoids on the dialysis clinic, family planning clinic, medical clinic and behavioral health clinic fee schedules.

For procedure codes that are not priced on the January 2023 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.

In addition, in the existing approved Medicaid State Plan regarding the Medication-Administered Treatment (MAT) Benefit Category, the state assured coverage of Naltrexone, Buprenorphine, and Methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262). Consistent with that federally required and approved Medicaid State Plan methodology, the following procedure code will be added to the behavioral health clinic fee schedule: J0575 Buprenorphine/naloxone, oral, greater than 10 mg buprenorphine. This code is not currently on the January 2023 Medicare ASP drug pricing file; instead, it will be manually priced in accordance with the methodology described in the paragraph above. This code is not currently on the January 2023 Medicare ASP drug pricing file; instead, it will be manually priced in accordance with the physician-administered drug reimbursement methodology described in the paragraph above for drugs not listed on the ASP pricing file.

Sixth, this SPA updates the rates for applicable long-acting reversible contraceptive (LARC) devices in order to ensure that the rate continues to align with the providers’ cost of obtaining the applicable device. Specifically, the rate based on section 340B of the Public Health Services Act for the LARC device code J7300 Intraut copper contraceptive (ParaGard) will be updated to $297.57 on the family planning clinic fee schedule when provided by family planning clinics and Federally Qualified Health Centers (FQHCs).

Lastly, this SPA increases rates for children’s behavioral health home-based rehabilitation services by 15%, which are provided by behavioral health clinics and are codes that are listed on the behavioral health clinic fee schedule. The purpose of this rate increase is to expand access to children’s behavioral health home-based rehabilitation services for Medicaid members, especially youth with behavioral health conditions. Specifically, the following children’s behavioral health home-based rehabilitation procedure codes are being increased:

|  |  |  |
| --- | --- | --- |
| **Procedure Code** | **Description** | **Proposed Fee** |
| H2019 | Therapeutic behavioral health services | $22.49 |
| H2019 HK | Therapeutic behavioral health services w/ modifier | $36.87 |
| T1017 | Targeted case management | $22.49 |
| T1017 HK | Targeted case management w/ modifier | $36.87 |

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 the updates to the dialysis and ambulatory surgical center clinic fee schedules will not change annual aggregate expenditures in State Fiscal Year (SFY) 2023 and SFY 2024.

DSS estimates that the changes to the rehabilitation clinic fee schedule described above will increase annual aggregate expenditures by approximately $87,647 in SFY 2023 and $216,664 in SFY 2024.

DSS estimates that adding the CoCM codes to the medical clinic fee schedule will increase annual aggregate expenditures by approximately $152,079 in SFY 2023 and $501,252 in SFY 2024.

DSS estimates that collectively, the LARC device rate increase and the various physician-administered drug reimbursement updates described above (including the MAT code addition) will reduce annual aggregate expenditures by approximately $14,644 in SFY 2023 and $36,146 in SFY 2024. All physician-administered drug changes referenced above other than those added to the dialysis clinic fee schedule either had a small increase in projected annual aggregate expenditures or no change. As noted above, these reimbursement updates simply align with updates to federal drug pricing files or methodologies as required by the existing approved Medicaid State Plan.

DSS estimates that increasing the rates for behavioral health home-based rehabilitation services will increase annual aggregate expenditures by approximately $1,110,417 in SFY 2023 and $2,691,650 in SFY 2024.

**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](mailto: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 23-G: Clinic Services – HIPAA Compliance Billing Code and Reimbursement Updates and Rate Increase for Children’s Behavioral Health Home-Based Rehabilitation Services”.

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 11, 2023.

**Attachment 4.19-B**

**Page 1(b)**

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**State Connecticut**

9. Clinic services – Rates for freestanding clinics are set as follows:

(a) Ambulatory Surgical Centers: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of ambulatory surgical center services. The agency’s fee schedule rates were set as of January 1, 2023 and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: <https://www.ctdssmap.com>. From this web page, go to “Provider,” then to “Provider Fee Schedule Download,” then select the applicable fee schedule.

TN # 23-G Approval Date\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date 01-01-2023

Supersedes

TN # 22-0008

**Attachment 4.19-B**

**Page 1(b)i**

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**State Connecticut**

(b) Dialysis Clinics: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of dialysis clinic services. The agency’s fee schedule rates were set as of January 1, 2023 and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: <https://www.ctdssmap.com>. From this web page, go to “Provider,” then to “Provider Fee Schedule Download,” then select the applicable fee schedule.

TN # 23-G Approval Date\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date 01/01/2023

Supersedes

TN # 22-0017

**Attachment 4.19-B**

**Page 1(b)ii**

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**State: CONNECTICUT**

1. Family Planning Clinics: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of family planning clinic services. The agency’s fee schedule rates were set as of January 1, 2023 and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: <https://www.ctdssmap.com>. From this web page, go to “Provider,” then to “Provider Fee Schedule Download,” then select the applicable fee schedule.

TN # 23-G Approval Date\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date 01-01-2023

Supersedes

TN # 22-0035

**Attachment 4.19-B**

**Page 1(c)**

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**State Connecticut**

1. Medical Clinics: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of medical clinic services. The agency’s fee schedule rates were set as of January 1, 2023 and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: <https://www.ctdssmap.com>. From this web page, go to “Provider,” then to “Provider Fee Schedule Download,” then select the applicable fee schedule.

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Supersedes

TN # 22-0035

**Attachment 4.19-B**

**Page 1(c)i**

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**State of Connecticut**

(e) Behavioral Health Clinics: (e.1) **Private Behavioral Health Clinics.** Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of behavioral health clinic services. The agency’s fee schedule rates for private behavioral health clinic services were set as of January 1, 2023 and are 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. All rates are published on the Connecticut Medical Assistance Program website: <https://www.ctdssmap.com>. From this web page, go to “Provider,” then to “Provider Fee Schedule Download,” then select the applicable fee schedule.

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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Supersedes

TN # 22-0008

**Attachment 4.19-B**

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**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**State of Connecticut**

(f) Rehabilitation Clinics:

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of rehabilitation clinic services. The agency’s fee schedule rates were set as of January 1, 2023 and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: <https://www.ctdssmap.com>. From this web page, go to “Provider,” then to “Provider Fee Schedule Download,” then select the applicable fee schedule.

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Supersedes

TN # 22-0024

Supplement 1b to

Attachment 4.19-B Page 4

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE CONNECTICUT

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**13. d. Rehabilitative Services**

1. **Behavioral Health Rehabilitation Services Pursuant to EPSDT**

(A) Fee Schedule. The agency’s fixed fees were set as of January 1, 2023 and are effective for services rendered on or after that date. Fees are the same for both governmental and non-governmental providers. All fees are published on the agency’s website at [www.ctdssmap.com](http://www.ctdssmap.com). Except as otherwise specified below, this fee schedule applies to all behavioral health rehabilitation services pursuant to EPSDT specified immediately below.

(B) Office-Based Off-Site Rehabilitation Services. Office-based off-site rehabilitation services include the routine outpatient behavioral health services codes on the behavioral health clinic fee schedule, each of which is paid at the same rate as the behavioral health clinic fee schedule referenced in section 9 of Attachment 4.19-B, except for office-based off-site rehabilitation services provided by a Federally Qualified Health Center (FQHC), which are paid at the FQHC’s behavioral health encounter rate established in accordance with section 2 of Attachment 4.19-B.

(C) Home and Community-Based Rehabilitation Services. Home and community-based rehabilitation services provided by an FQHC are paid using the fee schedule referenced in (A) above, not the FQHC’s encounter rate. When home and community-based rehabilitation services are delivered by more than one staff member, each staff member may bill for time spent engaged in rehabilitative services, whether the staff members are working together as a team or independently. When more than one staff member is in the home at the same time co-facilitating a family therapy or crisis intervention, each staff member may bill for the time spent engaged in this activity. All providers qualified to provide rehabilitation services receive the same payment rate regardless of the qualifications of the direct service staff.

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