STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 23-U: Coverage and Payment Modifications for the Transition from the Coronavirus Disease 2019 (COVID-19) Federal Public Health Emergency (PHE)

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). Public comment information is at the bottom of this document.

Proposed Changes to Medicaid State Plan

Effective on or after May 12, 2023, which is the first day after the scheduled end of the federal Coronavirus Disease 2019 (COVID-19) public health emergency (PHE), this SPA will Attachments 3.1-A, 3.1-B, 3.1-K, and 4.19-B of the Medicaid State Plan to make the updates detailed below. Fee schedules are published at this link: https://www.ctdssmap.com, then select "Provider", then select "Provider Fee Schedule Download," then select the applicable fee schedule. Whenever fee schedules are referenced, they incorporate the fee schedule rates for the applicable dates as posted on the fee schedule accessible from that webpage.

As explained in more detail below in the context of each proposed change included in this SPA, the overall purpose of this SPA is to continue certain flexibility under various approved disaster relief SPAs and submitted proposed disaster relief SPA 23-0005, which are governed by the flexibility in standard federal requirements implemented by CMS and pursuant to the state's approved waiver from CMS pursuant to section 1135 of the Social Security Act during the federally declared national emergency and PHE to help assist with the state's response to the COVID-19 pandemic and its effects. In accordance with federal requirements, all COVID-19 disaster relief SPAs will sunset no later than the last day of the federal PHE, which, as communicated by the federal government, will be May 11, 2023.

Home Health Services Reimbursement. There will be payments made in July 2023, November 2023, and March 2024 for qualifying home health agency providers, who will be eligible for receive payments calculated based on 2% of expenditures for the prior four months, so long as the provider meets the benchmarks set forth in the SPA pages, which include, as applicable, standards related to training, surveys, and health information exchange participation. For six-month periods after March 2024, the value-based payment will change from the progressive benchmark payments to outcome-based payments with outcome measures set forth in the SPA pages related to decreasing avoidable hospitalization, increasing percent of people who need ongoing services discharged from hospital to community in lieu of nursing home, and increase in probability of return to community within 90 days of nursing home admission. Payments are based on up to 2%

of expenditures for the 6 months that immediately precede each payment other than the first outcome payment which will be based on the 4 months that immediately precede the first payment.

The purpose of this portion of the SPA is to continue implementing, with respect to home health services, relevant provisions of the state's Spending Plan for Implementation of the American Rescue Plan Act (ARPA) of 2021, Section 9817, as updated, which relates to Home and Community-Based Services (HCBS) (ARPA HCBS Spending Plan). The purpose of the ARPA HCBS Spending Plan, in turn, is to improve the quality, access, and infrastructure for HCBS, as defined in that federal law and associated CMS guidance.

Community First Choice (CFC) Coverage and Reimbursement.

CFC Provisions Related to ARPA HCBS Spending Plan

Also consistent with implementing relevant provisions of the ARPA HCBS Spending Plan in improving access, quality and infrastructure for HCBS, this SPA makes the following coverage and reimbursement expansions. This SPA adds remote supports, which is defined in more detail in the SPA pages and includes the provision of supports by staff at a remote location who are engaged with the individual through technology/devices with the capability for live two-way communication. Individual interaction with the staff person may be scheduled, on-demand, or in response to an alert from a device in the remote support equipment system. Note that the equipment is already covered under the assistive technology service portion of this benefit. In order to provide remote live supports, the provider entity must be certified by DSS as a community hub. This SPA also expands the coverage definition of assistive technology to specifically reference remote equipment.

Note that other SPA provisions related to CFC for implementation of the ARPA HCBS Spending Plan are included in proposed SPA 23-0005-A (as are similar provisions related to the section 1915(i) Connecticut Home Care Program for Elders (CHCPE) and the section 1915(i) Connecticut Housing Engagement and Support Services (CHESS)).

CFC Provisions Continuing Certain Disaster Relief SPA Flexibilities

This SPA continues the following flexibilities for the Community First Choice (CFC) benefit pursuant to section 1915(k) of the Social Security Act included in one or more approved disaster relief SPAs:

- First, although beneficial for care planning and service delivery for the attendant care category of service to be provided in person whenever feasible, to the extent clinically appropriate for each individual based on that person's circumstances, care planning and service delivery for attending care services may be continued to be provided virtually, subject to the state's approval on a case-by-case basis.
- Second, the provider qualifications for providers of agency-based support and planning coach services are broadened to enable, as a substitute for five years of experience in a

professional capacity in a disability or health organization, to also allow five years of personal experience managing supports and services in the community either as a person with a disability or as a parent of a child with a disability, except that parents cannot provide this service for their own children. All other relevant qualifications remain in effect.

- Third, although beneficial for the assessment to be conducted in person, to the extent clinically appropriate for each individual based on that person's circumstances, all or part of the assessment may be provided virtually, subject to the state's approval on a case-by-case basis.

The purpose of the proposed change described above is to maintain virtual options for access to those relevant services when clinically appropriate to help improve choice and access for CFC participants.

Moving Clinic Mental Health Services to the Rehabilitation Services Benefit Category. In guidance issued by CMS earlier in the PHE, CMS detailed that it interprets the federal clinic regulation (42 C.F.R. § 440.90) to require that for telehealth to be billed by a clinic within the clinic Medicaid State Plan benefit category, either the clinic's practitioner or the member must be located in a licensed location of the clinic. During the PHE, the state requested, and CMS approved, a disaster relief waiver under section 1135 of the Social Security Act allowing the state to cover telehealth services provided by a clinic even if neither the practitioner nor the member was located in a licensed location of that clinic. That section 1135 waiver will expire automatically at the end of the federal PHE. The purpose of this portion of the SPA is to enable the state to have the flexibility to cover mental health services provided by a clinic via telehealth when neither the clinic practitioner nor the member is in a licensed location of the clinic. Note that this flexibility is still subject to the broader DSS telehealth policy regarding requirements and procedures for telehealth, which this SPA is not changing.

In order to enable continuation of this flexibility, this portion of the SPA will move mental health services provided by behavioral health clinics, medical clinics, and rehabilitation clinics from the federal Medicaid State Plan clinic benefit category defined by federal regulation at 42 C.F.R. § 440.90 to the federal Medicaid State Plan rehabilitative services benefit category defined by federal regulation at 42 C.F.R. § 440.130(d). This change will apply both to privately operated clinics and to public clinics operated by the State of Connecticut Department of Mental Health and Addiction Services (DMHAS). This change applies only to mental health services and only to freestanding behavioral health clinics, medical clinics, and rehabilitation clinics currently enrolled with DSS as clinic provider types. This change does not apply to federally qualified health centers (FQHCs) or outpatient hospitals because those federal regulations are more flexible in this context and do not include the restrictions on telehealth that CMS has interpreted to the clinic regulation, as referenced above. This change also does not apply to substance use disorder (SUD) services, because those services were previously moved to the federal Medicaid State Plan rehabilitation services benefit category through approved SPA 22-0020, which was coordinated with the state's approved SUD demonstration waiver pursuant to section 1115 of the Social Security Act.

This SPA does not make any substantive changes to coverage or reimbursement in this context, simply moving existing covered services and reimbursement methodology from the federal clinic benefit category to the federal rehabilitation services benefit category. Rates, reimbursement methodology, and coverage all remain the same. The purpose of this change is set forth above to maintain the state's ability to cover telehealth in the context as described above.

Removing Restrictive Language for Audio-Only Services and Reimbursement for Specified Covered Audio-Only Services. In order to enable the state to continue covering telehealth services, including where applicable and covered in accordance with DSS policy, audio-only services, this SPA removes language in the coverage pages for the physician services benefit category that currently indicates that services provided over the telephone are not covered. Related, this SPA also reflects the addition of audio-only billing codes to the physician office and outpatient fee schedule, which were previously added by one or more approved COVID disaster relief SPAs, which expire automatically at the end of the PHE. Specifically, the following codes are added:

Procedure Code	Description	Rate
99442	Physician telephone patient service, 11-20 minutes of medical discussion	$42.93
99443	Physician telephone patient service, 21-30 minutes of medical discussion	$64.99

Laboratory Coverage Flexibility. In order to maintain access to COVID-19 laboratory settings, this SPA continues the state's election of the laboratory flexibilities authorized in federal regulation under 42 C.F.R. § 440.30(d), which were made in one or more approved disaster relief SPAs, which are expiring at the end of the PHE. Specifically, in accordance with that regulation through the end of the PHE and period of active surveillance as defined in that regulation, the state chooses to cover COVID-19 laboratory testing or other testing for such other infectious disease named in a future federal PHE (1) without a physician's order and (2) in places of service (POS) other than an office or laboratory location, which can allow pop-up testing sites and other non-traditional locations for testing.

The purpose of this change is to maintain access to COVID-19 tests and to promote public health.

COVID-19 Vaccine Reimbursement. Consistent with approved SPA 22-0013 and continuing the reimbursement that was in effect through one or more approved disaster relief SPAs, this SPA continues the current reimbursement methodology for COVID-19 vaccine administration and vaccines for pharmacy providers and for the applicable fee schedules (physician (when provided by physicians, nurse practitioners, physician assistants, and certified nurse-midwives and for this service, all of those practitioners will be paid at 100% of the fee on the physician fee schedule), home health agency (regardless of whether the beneficiary is otherwise receiving home health services), hospice agency (regardless of whether the beneficiary is otherwise receiving hospice

services), medical clinic, dialysis clinic, and family planning clinic) to be 100% of Medicare from dates of service May 12, 2023 through September 30, 2024.

Additionally, for dates of service May 12, 2023 through September 30, 2024, this SPA will reimburse the COVID-19 vaccine product, when commercially purchased, at 100% of the Medicare rate, or in the absence of a Medicare rate, in accordance with the federally approved Medicaid State Plan provisions regarding physician-administered drugs, 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 the Centers for Medicare and Medicaid Services;
- 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.

COVID-19 vaccine administration and vaccine product will be reimbursed to the following providers: Physicians, Physician Assistants, Advanced Practice Registered Nurses, Certified Nurse Midwives, Medical Clinics, Family Planning Clinics, Dialysis Clinics, Federally Qualified Health Centers, Outpatient Hospitals, Hospice Agencies, Home Health Agencies, Dentists, and Pharmacies.

The state will review the reimbursement level for dates of service October 1, 2024 forward at a future time and in a future SPA.

The purpose of this change is to maintain access to COVID-19 vaccine administration and vaccines.

COVID-19 Testing Reimbursement. Finally, consistent with approved SPA 22-0013 and continuing the reimbursement that was in effect through one or more approved disaster relief SPAs this SPA will update COVID-19 testing reimbursement rates for dates of service May 12, 2023-September 30, 2024. This update is to continue to allow payment of COVID lab tests to be reimbursed at 100% of current Medicare rates during that time frame, which applies to the independent laboratory, physician, dialysis clinic, family planning clinic, and medical clinic fee schedules. The state will review the reimbursement level for dates of service October 1, 2024 forward at a future time and in a future SPA, reflecting in part the consideration that the laboratory fee schedule is generally set at 70% of Medicare rates.

Estimated Fiscal Impact

Home Health. DSS estimates that the home health reimbursement increases will increase annual aggregate expenditures by approximately $3,334,942 in SFY 2023, $7,665,854 in SFY 2024, and $2,816,476 in SFY 2025.

Removing Restrictive Language for Physician Services Performed via Audio-Only. DSS estimates that removing the restrictions on coverage for audio-only services and maintaining the reimbursement for the audio-only procedure codes set forth above will increase annual aggregate expenditures by approximately $943,528 in SFY 2023, $971,834 in SFY 2024 and $1,000,989 in SFY 2025.

CFC. DSS does not anticipate any significant fiscal impact from the portions of this SPA that extend specified provisions from the approved disaster relief SPAs because those pieces simply provide more flexibility in terms of the mode of accessing the service or in the qualifications of providers, as applicable, but they do not change actual coverage or reimbursement. DSS estimates that the ARPA HCBS CFC coverage and reimbursement expansions will increase annual aggregate expenditures by approximately $30,000 in SFY 2023, $218,822 in SFY 2024 and $693,346 in SFY 2025.

Mental Health Services in Clinics. DSS does not anticipate any significant fiscal impact from the portion of this SPA that moves mental health services provided by freestanding clinics from the federal clinic benefit category to the federal rehabilitation services benefit category because the substantive coverage and reimbursement are not changing.

Laboratory Coverage Flexibility. At this time, DSS does not anticipate any significant fiscal impact from the portion of this SPA that continues the flexibility to cover COVID-19 laboratory tests without a physician order and/or in a setting other than laboratory or office. However, if it were ever to become necessary to expand COVID-19 testing in those contexts back to peak pandemic levels, then continuing this flexibility would be associated with approximately $1,000,000 in monthly gross expenditures (or annualized to approximately $12,000,000 in annual aggregate expenditures).

COVID-19 Testing Reimbursement. DSS estimates that the portion of this SPA maintaining reimbursement at 100% of Medicare for COVID-19 testing for the May 12, 2023 through September 30, 2024 period is likely to result in increasing annual aggregate expenditures by approximately $2,315,110 in SFY 2023, $20,666,213 in SFY 2024 and $5,321,550 in SFY 2025.

COVID-19 Vaccines and Vaccine Administration Reimbursement. DSS estimates that the portion of this SPA maintaining reimbursement at 100% of Medicare for COVID-19 vaccines and vaccine administration for the May 12, 2023 through September 30, 2024 period is likely to result in increasing annual aggregate expenditures by approximately $13,640 in SFY 2023, $121,764 in SFY 2024 and $31,354 in SFY 2025.

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). When feasible and relevant, the versions of the SPA pages posted to that

webpage include track changes indicating this SPA's proposed changes to the current version of the Medicaid State Plan.

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 23-U: Coverage and Payment Modifications for the Transition from the Coronavirus Disease 2019 (COVID-19) Federal Public Health Emergency (PHE)".

Anyone may send DSS written comments about this SPA. **Written comments must be received by DSS at the above contact information no later than May 24, 2023**.

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CATEGORICALLY NEEDY GROUP(S): ALL

c. Federally Qualified Health Center (FQHC) Services

(1) General. Federally Qualified Health Center (FQHC) services are defined in section 1905 (a) (2) (C) of the Social Security Act (the Act). FQHC services include services provided by physicians, nurse practitioners, physician assistants, nurse midwives, clinical psychologists, licensed clinical social workers, and other ambulatory services included in the state plan. FQHC services also include services and supplies that are furnished incident to professional services furnished by a physician, physician assistant, nurse practitioner, or nurse midwife.

Encounters with more than one health professional for the same type of service and multiple interactions with the same health professional that take place on the same day constitute a single encounter except when the patient after the first interaction, suffers illness or injury requiring additional diagnosis and treatment. Medicaid pays for one medical encounter, one behavioral health encounter and one dental encounter per day.

Limitations on other ambulatory services furnished in the FQHC are the same limitations as defined for those services in the state plan.

(2) Dental Services Provided by FQHCs. The following additional provisions apply for dental services provided by FQHCs:

A. Nonemergency dental services provided by FQHCs require prior authorization, except for diagnostic, prevention, basic restoration procedures and nonsurgical extractions that are consistent with standard and medically necessary dental practices.

B. FQHC dental clinics must be licensed under Regulations of Connecticut State Agencies Sections 19-13-D45 to 19-13-D53, inclusive.

C. The Department will only pay for orthodontia for individuals under twenty-one (21) years of age.

D. Services must meet the requirements of 42 CFR 440.100 and are limited to the dental provider's scope of practice.

~~**3. Other Laboratory and X-Ray Services.** No limitation on services.~~

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3. Other Laboratory and X-Ray Services. No limitation on services. Pursuant to 42 CFR 440.30(d), the state covers laboratory tests (including self-collected tests authorized by the FDA for home use) that do not meet one or more conditions specified in 42 CFR 44.30(a) and (b).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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f. 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~~.

g. 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~~.

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

~~i.~~h. The Department will not pay for cosmetic surgery.

~~j.~~i. 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.

~~k.~~j. The Department will not pay for cancelled office visits or for appointments not kept.

~~l.~~k. Services are limited to those listed in the Department's fee schedule.

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

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

~~o.~~n. No more than eight (8) persons per psychiatric group therapy session.

~~p.~~o. 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.

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d. Medical Clinics licensed by the Department of Public Health ~~under Section 19-13-D45 of the Regulations of Connecticut State Agencies~~. Limitation: No more than one (1) visit per day of the same type of service per recipient. Behavioral health services provided by medical clinics are moved to the Rehabilitative Services benefit category section of the Medicaid State Plan (42 CFR § 440.130(d)).

~~e.~~ Behavioral Health Clinics (also known as Mental Health and Substance Abuse Clinics): ~~(a) licensed by the Department of Public Health as a Psychiatric Outpatient Clinic for Adults, a Mental Health Day Treatment Facility, or a Facility for the Care or Treatment of Substance Abusive or Dependent Persons; (b) licensed by the Department of Children and Families as an Outpatient Psychiatric Clinic for Children; or (c) operated by the Department of Mental Health and Addiction Services. Services include, but are not limited to, routine outpatient, intensive outpatient, day treatment, partial hospitalization, and other behavioral health clinic services authorized in accordance with state law within the scope of the clinic's license. Limitations:~~

~~(1) No more than one (1) therapy session of the same type per day per clinic for the same recipient.~~

~~(2) No more than one (1) psychiatric diagnostic evaluation per performing provider per episode of care for the same recipient. For clinics operated by the Department of Mental Health and Addiction Services, no more than one (1) psychiatric / psychological evaluation per performing provider, per episode of care for the same recipient, but no more frequently than one per year, which may be exceeded by prior authorization based on medical necessity.~~

~~(3) No more than twelve (12) persons per group therapy session provided to individuals in routine outpatient settings. Limitation does not apply to multi-family groups or intermediate care programs.~~Services provided by behavioral health clinics are moved to the Rehabilitative Services benefit category section of the Medicaid State Plan (42 CFR § 440.130(d)).

~~f.~~e. Rehabilitation Clinics accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) on the Joint Commission on Accreditation ~~-~~of Healthcare Organization (JCAHO). A copy of the medical director's current physician license and statement accepting full professional responsibility for the services are also required. Behavioral health services provided by rehabilitation clinics are moved to the Rehabilitative Services benefit category section of the Medicaid State Plan (42 CFR § 440.130(d)). Limitations:

(1) No more than one (1) complete evaluation per year involving the same treatment modality per provider for the same recipient.
(2) No more than one (1) full impedence battery, tympanometry test or electronystagmography per provider clinic for the same recipient per year.
(3) No more than one (1) treatment session per day for the same procedure per provider clinic for the same recipient.

~~g.~~f. Methadone Maintenance Clinics licensed by the Department of Public Health ~~under Section 19a-495-570 of the Regulations of Connecticut State Agencies~~.

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13.d. Rehabilitative Services

MENTAL HEALTH SERVICES PROVIDED BY CLINCS (42 C.F.R. § 440.130(d))

A. Overview

Mental health services provided by clinics (specifically, mental health services provided by behavioral health clinics and all behavioral health services provided by medical clinics and rehabilitation clinics, each as defined below) are provided as part of a continuum of services and are available to all Medicaid-eligible individuals of all ages for whom mental health services are medically necessary. For medical clinics and rehabilitation clinics, this section applies only to mental health services provided by those clinics. Note that substance use disorder (SUD) services are described in a separate section within this rehabilitative services benefit category section of the Medicaid State Plan. Services must be medically necessary and recommended by an independent licensed practitioner, as defined below, to promote the maximum reduction of symptoms and/or restoration of an individual to the best possible functional level according to an individualized treatment plan, which includes, as applicable, assistance with recovery from one or more mental health conditions and/or restoration of an individual to a normal developmental trajectory.

As detailed below, the scope of services provided as part of mental health services provided by clinics include, but are not limited to, routine outpatient, intensive outpatient, day treatment, partial hospitalization, and other mental health services authorized in accordance with state law within the scope of the clinic's license, as applicable to the clinic.

B. Service Components

1. **Assessment and Individualized Plan Development**

    a. Component Description: The development of an individualized person-centered treatment plan addresses the individual's diagnosis or diagnoses and assessed needs, including the type, amount, frequency, and duration of services to be provided, and the specific goals and objectives developed based on the evaluation and diagnosis to attain or maintain a member's achievable level of independent

b. functioning. The individualized treatment plan must be person-centered and developed in collaboration with the individual and any other persons chosen by the individual to participate in the development of the treatment plan, including family members, when appropriate and when for the direct benefit of the beneficiary.

c. Qualified Practitioners: Independent licensed practitioners (defined below); and associate licensed practitioners (defined below) or graduate level intern, working under the direct supervision of a physician or independent licensed practitioner, who is otherwise qualified to perform services under the applicable clinic licensure category. The independent licensed practitioner must also sign each assessment and treatment plan performed by an associate licensed practitioner or graduate-level intern.

2. **Therapy**

a. Component Description: Individual, group, couples, and family therapy, or any combination thereof, as medically necessary based on the beneficiary's treatment plan, to address an individual's major lifestyle, attitudinal, and behavioral problems. This component focuses on symptom reduction associated with the individual's diagnosis(es), stabilization and restoration to the person's best possible functional level, including use of appropriate evidence-informed practices. Collateral contact is permitted as needed to address the therapeutic goals of the Medicaid beneficiary receiving treatment. Any family therapy must be for the direct benefit of the beneficiary.

a. Qualified Practitioners: Independent licensed practitioners; and associate licensed practitioners or non-licensed or non-certified individuals, working under the direct supervision of an independent licensed practitioner.

3. **Health Services and Medication Management**

a. Component Description: This component includes any combination of the following as medically necessary for each person: health assessments, health monitoring, health education requiring a medical license (in one of the categories of qualified practitioners for this service) for an individual or group session with members to learn specific ways of coping and progressing in their recovery. Psychotropic and other medication management (including prescribing, monitoring, administration and observation of self-administration, as applicable) are provided to the extent medically necessary and as permitted under state law.

b. Qualified Practitioners: Physicians, advanced practice registered nurses, physician assistants, registered nurses, and licensed practical nurses, each of whom must be licensed under state law and acting within the person's scope of practice under state law.

4. **Service Coordination**

a. Component Description: This component includes assisting with coordination of services necessary to meet the individual's needs and service planning for Medicaid-covered services, and referral and linkage to other Medicaid-covered services. Service coordination entails the coordination by the provider with Medicaid-covered services outside of the services performed by the provider or in the provider's facility, including medical care. Standalone service coordination is covered for beneficiaries under age 19. Otherwise, it is covered as a component of another applicable service.

b. Qualified Practitioners: Independent licensed practitioners; associate licensed practitioners; registered nurses; licensed practical nurses; and non-licensed or non-certified individuals. All individuals other than independent licensed practitioners must work under the supervision of an independent licensed practitioner or other applicable qualified supervising practitioner as set forth below in the definition for each category of practitioner.

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5. Intermediate Intensity Services

a. Component Description: This component includes: (i) intensive outpatient services (IOP), which is an integrated program of outpatient psychiatric services that are more intensive treatment than routine outpatient psychiatric services and (ii) partial hospitalization program (PHP) which has the same meaning as provided in sections 1861(ff)(1) to 1861(ff)(3), inclusive, of the Social Security Act.

b. Qualified Practitioners: Independent licensed practitioners; and associate licensed practitioners or non-licensed or non-certified individual, working under the direct supervision of an independent licensed practitioner.

C. Provider Qualifications

1. Provider Entity Qualifications

Mental health services provided by clinics must be provided by an entity licensed by the state as a behavioral health clinic (also known as mental health and substance abuse clinics, psychiatric outpatient clinics, outpatient psychiatric clinics, or similar names), medical clinic, or rehabilitation clinic or be provided by a clinic operated by the Department of Mental Health and Addiction Services. To the extent applicable, each provider entity must obtain all licenses applicable to all age cohorts (children, adults, or both) that it serves.

For services provided outside the state in accordance with 42 C.F.R. § 431.52, the provider entity and each practitioner employed by or working under contract to the entity must have comparable credentials in the state in which the facility is located.

Qualified providers under this section do not include inpatient or outpatient hospitals or individually enrolled physicians or other licensed practitioners because mental health services performed by those providers remain separately covered in each of the applicable benefit categories for those providers, as detailed in sections 1, 2, 5, and 6, as applicable, of Attachment 3.1-A of the Medicaid State Plan.

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2. Practitioner Qualifications

Mental health services detailed in this section must be performed by practitioners employed by or under contract to qualified provider entities who meet the following qualifications:

a. General Qualifications: To the extent applicable for each service component, as set forth above, eligible practitioners include licensed and non-licensed professional staff, who are employed or contracted to an eligible provider entity, are at least 18 years of age, have at least a high school diploma or equivalent general education degree (GED) or such additional education necessary to provide specific services, plus other required qualifications as set forth by state law or other requirements for each category of service provided.

a. Supervision: Anyone providing mental health services other than an Independent Licensed Practitioner must be under the direct supervision of an Independent Licensed Practitioner to the full extent necessary based on the services provided and the person's qualifications. The Independent Licensed Practitioner must perform required supervision and must accept primary responsibility for the mental health services performed by the applicable practitioner.

b. Independent Licensed Practitioner: Any of the following categories of individuals who are licensed under state law and acting within their scope of practice under state law: physicians, licensed psychologists, licensed clinical social workers, licensed marital and family therapists, licensed professional counselors, licensed alcohol and drug counselors, advanced practice registered nurses, or physician assistants.

c. Associate Licensed Practitioner: Any of the following categories of individuals who are licensed under state law and acting within their scope of practice under state law, including applicable supervision requirements: licensed master social worker, licensed professional counselor associate, licensed marital and family therapy associate, and any other comparable associate licensure for a category of practitioner included in the definition of independent licensed practitioner in which the associate license requires, at a minimum, that the

individual has received a graduate degree that is required for the comparable independent licensed practitioner category. The associate licensed practitioner works under the supervision of an applicable independent licensed practitioner as set forth in the applicable scope of practice.

d. Non-licensed or non-certified individuals: Any individual who does not meet the requirements for any of the other practitioner categories set forth in this section and who works under the supervision of an independent licensed practitioner.

e. Graduate-Level Intern: Must be actively enrolled in an accredited graduate degree program at an accredited college or university that: (1) once completed, would satisfy the graduate education requirements for one or more categories of independent licensed practitioner and (2) requires students to participate in intern placements for clinical training in the provision of behavioral health services. The graduate-level intern must receive weekly clinical supervision from an independent licensed practitioner who is the intern's site-supervisor and also supervision from the intern's graduate degree program. This supervision must be conducted in accordance with the standards outlined by the sponsoring graduate degree program and any relevant graduate education accreditation body or bodies applicable to the degree program.

f. Licensed Practical Nurse: Licensed under state law as a licensed practical nurse and working under the person's scope of practice in accordance with state law.

g. Registered Nurse: Licensed under state law as a registered nurse and working under the person's scope of practice in accordance with state law.

D. Limitations

(1) No more than one (1) therapy session of the same type per day per clinic for the same recipient.

(1) No more than one (1) psychiatric diagnostic evaluation per performing provider per episode of care for the same recipient. For clinics operated by the Department of Mental Health and Addiction Services, no more than one (1) psychiatric / psychological evaluation per performing provider, per episode of care for the same recipient, but no more frequently than one per year, which may be exceeded by prior authorization based on medical necessity.

(2) No more than twelve (12) persons per group therapy session provided to individuals in routine outpatient settings. Limitation does not apply to multi-family groups or intermediate care programs.

E. Excluded Services

The following services are excluded from coverage:

1. Components that are not provided to or directed exclusively for the treatment of the Medicaid eligible individual;
2. Services or components of services of which the basic nature is to supplant housekeeping or basic services for the convenience of a person receiving covered services; or
3. Services that are solely vocational or recreational.

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CATEGORICALLY NEEDY GROUP(S): ALL

c. Federally Qualified Health Center (FQHC) Services

(1) General. Federally Qualified Health Center (FQHC) services are defined in section 1905 (a) (2) (C) of the Social Security Act (the Act). FQHC services include services provided by physicians, nurse practitioners, physician assistants, nurse midwives, clinical psychologists, licensed clinical social workers, and other ambulatory services included in the state plan. FQHC services also include services and supplies that are furnished incident to professional services furnished by a physician, physician assistant, nurse practitioner, or nurse midwife.

Encounters with more than one health professional for the same type of service and multiple interactions with the same health professional that take place on the same day constitute a single encounter except when the patient after the first interaction, suffers illness or injury requiring additional diagnosis and treatment. Medicaid pays for one medical encounter, one behavioral health encounter and one dental encounter per day.

Limitations on other ambulatory services furnished in the FQHC are the same limitations as defined for those services in the state plan.

(2) Dental Services Provided by FQHCs. The following additional provisions apply for dental services provided by FQHCs:

A. Nonemergency dental services provided by FQHCs require prior authorization, except for diagnostic, prevention, basic restoration procedures and nonsurgical extractions that are consistent with standard and medically necessary dental practices.

B. FQHC dental clinics must be licensed under Regulations of Connecticut State Agencies Sections 19-13-D45 to 19-13-D53, inclusive.

C. The Department will only pay for orthodontia for individuals under twenty-one (21) years of age.

D. Services must meet the requirements of 42 CFR 440.100 and are limited to the dental provider's scope of practice.

~~**3. Other Laboratory and X-Ray Services.** No limitation on services.~~

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3. Other Laboratory and X-Ray Services. No limitation on services. Pursuant to 42 CFR 440.30(d), the state covers laboratory tests (including self-collected tests authorized by the FDA for home use) that do not meet one or more conditions specified in 42 CFR 44.30(a) and (b).

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f. 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~~.

g. 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~~.

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

~~i.~~h. The Department will not pay for cosmetic surgery.

~~j.~~i. 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.

~~k.~~j. The Department will not pay for cancelled office visits or for appointments not kept.

~~l.~~k. Services are limited to those listed in the Department's fee schedule.

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

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

~~o.~~n. No more than eight (8) persons per psychiatric group therapy session.

~~p.~~o. 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.

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d. Medical Clinics licensed by the Department of Public Health ~~under Section 19-13-D45 of the Regulations of Connecticut State Agencies~~. Limitation: No more than one (1) visit per day of the same type of service per recipient. Behavioral health services provided by medical clinics are moved to the Rehabilitative Services benefit category section of the Medicaid State Plan (42 CFR § 440.130(d)).

~~e.~~ Behavioral Health Clinics (also known as Mental Health and Substance Abuse Clinics): ~~(a) licensed by the Department of Public Health as a Psychiatric Outpatient Clinic for Adults, a Mental Health Day Treatment Facility, or a Facility for the Care or Treatment of Substance Abusive or Dependent Persons; (b) licensed by the Department of Children and Families as an Outpatient Psychiatric Clinic for Children; or (c) operated by the Department of Mental Health and Addiction Services. Services include, but are not limited to, routine outpatient, intensive outpatient, day treatment, partial hospitalization, and other behavioral health clinic services authorized in accordance with state law within the scope of the clinic's license. Limitations:~~

~~(2) No more than one (1) therapy session of the same type per day per clinic for the same recipient.~~

~~(3) No more than one (1) psychiatric diagnostic evaluation per performing provider per episode of care for the same recipient. For clinics operated by the Department of Mental Health and Addiction Services, no more than one (1) psychiatric / psychological evaluation per performing provider, per episode of care for the same recipient, but no more frequently than one per year, which may be exceeded by prior authorization based on medical necessity.~~

~~(4) No more than twelve (12) persons per group therapy session provided to individuals in routine outpatient settings. Limitation does not apply to multi-family groups or intermediate care programs.~~Services provided by behavioral health clinics are moved to the Rehabilitative Services benefit category section of the Medicaid State Plan (42 CFR § 440.130(d)).

~~f.~~e. Rehabilitation Clinics accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) on the Joint Commission on Accreditation ~~-~~of Healthcare Organization (JCAHO). A copy of the medical director's current physician license and statement accepting full professional responsibility for the services are also required. Behavioral health services provided by rehabilitation clinics are moved to the Rehabilitative Services benefit category section of the Medicaid State Plan (42 CFR § 440.130(d)). Limitations:

(1) No more than one (1) complete evaluation per year involving the same treatment modality per provider for the same recipient.
(2) No more than one (1) full impedence battery, tympanometry test or electronystagmography per provider clinic for the same recipient per year.
(3) No more than one (1) treatment session per day for the same procedure per provider clinic for the same recipient.

~~g.~~f. Methadone Maintenance Clinics licensed by the Department of Public Health ~~under Section 19a-495-570 of the Regulations of Connecticut State Agencies~~.

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GROUP(S): ALL

13.d. Rehabilitative Services

MENTAL HEALTH SERVICES PROVIDED BY CLINCS (42 C.F.R. § 440.130(d))

F. Overview

Mental health services provided by clinics (specifically, mental health services provided by behavioral health clinics and all behavioral health services provided by medical clinics and rehabilitation clinics, each as defined below) are provided as part of a continuum of services and are available to all Medicaid-eligible individuals of all ages for whom mental health services are medically necessary. For medical clinics and rehabilitation clinics, this section applies only to mental health services provided by those clinics. Note that substance use disorder (SUD) services are described in a separate section within this rehabilitative services benefit category section of the Medicaid State Plan. Services must be medically necessary and recommended by an independent licensed practitioner, as defined below, to promote the maximum reduction of symptoms and/or restoration of an individual to the best possible functional level according to an individualized treatment plan, which includes, as applicable, assistance with recovery from one or more mental health conditions and/or restoration of an individual to a normal developmental trajectory.

As detailed below, the scope of services provided as part of mental health services provided by clinics include, but are not limited to, routine outpatient, intensive outpatient, day treatment, partial hospitalization, and other mental health services authorized in accordance with state law within the scope of the clinic's license, as applicable to the clinic.

G. Service Components

6. **Assessment and Individualized Plan Development**

a. Component Description: The development of an individualized person-centered treatment plan addresses the individual's diagnosis or diagnoses and assessed needs, including the type, amount, frequency, and duration of services to be provided, and the specific goals and objectives developed based on the evaluation and diagnosis to attain or maintain a member's achievable level of independent

b. functioning. The individualized treatment plan must be person-centered and developed in collaboration with the individual and any other persons chosen by the individual to participate in the development of the treatment plan, including family members, when appropriate and when for the direct benefit of the beneficiary.

c. Qualified Practitioners: Independent licensed practitioners (defined below); and associate licensed practitioners (defined below) or graduate level intern, working under the direct supervision of a physician or independent licensed practitioner, who is otherwise qualified to perform services under the applicable clinic licensure category. The independent licensed practitioner must also sign each assessment and treatment plan performed by an associate licensed practitioner or graduate-level intern.

7. **Therapy**

a. Component Description: Individual, group, couples, and family therapy, or any combination thereof, as medically necessary based on the beneficiary's treatment plan, to address an individual's major lifestyle, attitudinal, and behavioral problems. This component focuses on symptom reduction associated with the individual's diagnosis(es), stabilization and restoration to the person's best possible functional level, including use of appropriate evidence-informed practices. Collateral contact is permitted as needed to address the therapeutic goals of the Medicaid beneficiary receiving treatment. Any family therapy must be for the direct benefit of the beneficiary.

c. Qualified Practitioners: Independent licensed practitioners; and associate licensed practitioners or non-licensed or non-certified individuals, working under the direct supervision of an independent licensed practitioner.

8. **Health Services and Medication Management**

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a. Component Description: This component includes any combination of the following as medically necessary for each person: health assessments, health monitoring, health education requiring a medical license (in one of the categories of qualified practitioners for this service) for an individual or group session with members to learn specific ways of coping and progressing in their recovery. Psychotropic and other medication management (including prescribing, monitoring, administration and observation of self-administration, as applicable) are provided to the extent medically necessary and as permitted under state law.

b. Qualified Practitioners: Physicians, advanced practice registered nurses, physician assistants, registered nurses, and licensed practical nurses, each of whom must be licensed under state law and acting within the person's scope of practice under state law.

9. **Service Coordination**

a. Component Description: This component includes assisting with coordination of services necessary to meet the individual's needs and service planning for Medicaid-covered services, and referral and linkage to other Medicaid-covered services. Service coordination entails the coordination by the provider with Medicaid-covered services outside of the services performed by the provider or in the provider's facility, including medical care. Standalone service coordination is covered for beneficiaries under age 19. Otherwise, it is covered as a component of another applicable service.

b. Qualified Practitioners: Independent licensed practitioners; associate licensed practitioners; registered nurses; licensed practical nurses; and non-licensed or non-certified individuals. All individuals other than independent licensed practitioners must work under the supervision of an independent licensed practitioner or other applicable qualified supervising practitioner as set forth below in the definition for each category of practitioner.

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10. Intermediate Intensity Services

b. Component Description: This component includes: (i) intensive outpatient services (IOP), which is an integrated program of outpatient psychiatric services that are more intensive treatment than routine outpatient psychiatric services and (ii) partial hospitalization program (PHP) which has the same meaning as provided in sections 1861(ff)(1) to 1861(ff)(3), inclusive, of the Social Security Act.

d. Qualified Practitioners: Independent licensed practitioners; and associate licensed practitioners or non-licensed or non-certified individual, working under the direct supervision of an independent licensed practitioner.

H. Provider Qualifications

3. Provider Entity Qualifications

Mental health services provided by clinics must be provided by an entity licensed by the state as a behavioral health clinic (also known as mental health and substance abuse clinics, psychiatric outpatient clinics, outpatient psychiatric clinics, or similar names), medical clinic, or rehabilitation clinic or be provided by a clinic operated by the Department of Mental Health and Addiction Services. To the extent applicable, each provider entity must obtain all licenses applicable to all age cohorts (children, adults, or both) that it serves.

For services provided outside the state in accordance with 42 C.F.R. § 431.52, the provider entity and each practitioner employed by or working under contract to the entity must have comparable credentials in the state in which the facility is located.

Qualified providers under this section do not include inpatient or outpatient hospitals or individually enrolled physicians or other licensed practitioners because mental health services performed by those providers remain separately covered in each of the applicable benefit categories for those providers, as detailed in sections 1, 2, 5, and 6, as applicable, of Attachment 3.1-A of the Medicaid State Plan.

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4. Practitioner Qualifications

Mental health services detailed in this section must be performed by practitioners employed by or under contract to qualified provider entities who meet the following qualifications:

b. General Qualifications: To the extent applicable for each service component, as set forth above, eligible practitioners include licensed and non-licensed professional staff, who are employed or contracted to an eligible provider entity, are at least 18 years of age, have at least a high school diploma or equivalent general education degree (GED) or such additional education necessary to provide specific services, plus other required qualifications as set forth by state law or other requirements for each category of service provided.

h. Supervision: Anyone providing mental health services other than an Independent Licensed Practitioner must be under the direct supervision of an Independent Licensed Practitioner to the full extent necessary based on the services provided and the person's qualifications. The Independent Licensed Practitioner must perform required supervision and must accept primary responsibility for the mental health services performed by the applicable practitioner.

i. Independent Licensed Practitioner: Any of the following categories of individuals who are licensed under state law and acting within their scope of practice under state law: physicians, licensed psychologists, licensed clinical social workers, licensed marital and family therapists, licensed professional counselors, licensed alcohol and drug counselors, advanced practice registered nurses, or physician assistants.

j. Associate Licensed Practitioner: Any of the following categories of individuals who are licensed under state law and acting within their scope of practice under state law, including applicable supervision requirements: licensed master social worker, licensed professional counselor associate, licensed marital and family therapy associate, and any other comparable associate licensure for a category of practitioner included in the definition of independent licensed practitioner in which the associate license requires, at a minimum, that the

individual has received a graduate degree that is required for the comparable independent licensed practitioner category. The associate licensed practitioner works under the supervision of an applicable independent licensed practitioner as set forth in the applicable scope of practice.

k. Non-licensed or non-certified individuals: Any individual who does not meet the requirements for any of the other practitioner categories set forth in this section and who works under the supervision of an independent licensed practitioner.

l. Graduate-Level Intern: Must be actively enrolled in an accredited graduate degree program at an accredited college or university that: (1) once completed, would satisfy the graduate education requirements for one or more categories of independent licensed practitioner and (2) requires students to participate in intern placements for clinical training in the provision of behavioral health services. The graduate-level intern must receive weekly clinical supervision from an independent licensed practitioner who is the intern's site-supervisor and also supervision from the intern's graduate degree program. This supervision must be conducted in accordance with the standards outlined by the sponsoring graduate degree program and any relevant graduate education accreditation body or bodies applicable to the degree program.

m. Licensed Practical Nurse: Licensed under state law as a licensed practical nurse and working under the person's scope of practice in accordance with state law.

n. Registered Nurse: Licensed under state law as a registered nurse and working under the person's scope of practice in accordance with state law.

I. Limitations

(1) No more than one (1) therapy session of the same type per day per clinic for the same recipient.

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(3) No more than one (1) psychiatric diagnostic evaluation per performing provider per episode of care for the same recipient. For clinics operated by the Department of Mental Health and Addiction Services, no more than one (1) psychiatric / psychological evaluation per performing provider, per episode of care for the same recipient, but no more frequently than one per year, which may be exceeded by prior authorization based on medical necessity.

(4) No more than twelve (12) persons per group therapy session provided to individuals in routine outpatient settings. Limitation does not apply to multi-family groups or intermediate care programs.

J. Excluded Services

The following services are excluded from coverage:

1. Components that are not provided to or directed exclusively for the treatment of the Medicaid eligible individual;
2. Services or components of services of which the basic nature is to supplant housekeeping or basic services for the convenience of a person receiving covered services; or
3. Services that are solely vocational or recreational.

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Two individuals may share an Attendant.
The State assumes the cost for a comprehensive background check on all Attendants that an individual seeks to hire. The individual receives a copy of the results in order to make an informed decision as to whether to hire the Attendant. If any criminal record is found, the individual may elect to hire the Attendant but must sign a waiver stating that he or she is aware of and understands the criminal findings.

The CFC participant will include the cost of workers compensation coverage for their employees as part of their individual budget in accordance with Attachment 4.19-B of the Medicaid State Plan.

Limits on amount, duration or scope: The department assigns an overall budget based on need grouping that is determined by algorithm. Natural supports are based on the individual's functional assessment, which will take into consideration the availability of natural supports. Natural supports are identified during the person-centered service planning process and utilized when available to the individual. Natural supports are defined as voluntary unpaid care provided on a regular and consistent basis by a parent, spouse, or other person.
Although beneficial for care planning and service delivery for this category of service to be provided in person, to the extent clinically appropriate for each individual based on that person's circumstances, care planning and service delivery may be provided virtually, subject to the state's approval.

Transitional Services
Service Definition: Transitional services are non-recurring services for individuals who are transitioning from a nursing facility, institution for mental diseases, or intermediate care facility for individuals with intellectual disabilities to a home and community-based setting where the individual resides. Allowable transitional services are those necessary to enable a person to establish a basic household and may include:

- essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items and bed/bath linens;
- transportation expenses to pay for trips associated with locating housing;
- set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
- services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy.

Limit on amount and duration of scope: Transitional services funds are furnished only to the extent that they are necessary as determined through the service plan development process and

equipment and supplies that are necessary for the welfare of the individual. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the individual. Adaptations that add to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

Limit on amount and scope: The maximum benefit per individual over a 5 year period is $15,000. This benefit is in addition to the individual budget calculated by the need grouping.

Assistive Technology (AT)

Service Definition: Any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants to perform or seek assistance with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs). Assistive Technology meets the requirement under 42 C.F.R. § 441.520(b)(2), which provides for "expenditures relating to a need identified in an individual's person-centered service plan that increases an individual's independence or substitutes for human assistance, to the extent that expenditures would otherwise be made for the human assistance." Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device, including:

- services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices;
- services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; and/or
- training or technical assistance for the participant, Attendant, or where appropriate, the participant's family members, guardian, advocate or authorized representative.
- equipment used for remote supports such as a motion sensing system, radio frequency identification, live video feed, live audio feed, or web-based monitoring. Assistive technology equipment does not include non-technical, non-electronic equipment (e.g., grab bars or wheelchair ramps) or items otherwise available as environmental accessibility adaptations or specialized medical equipment and supplies.

Limit on amount and scope: The maximum allowance per individual is $5,000 per calendar year

A. Acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks.

Service Definition: Services to support the acquisition, maintenance, and enhancement of skill in order for the individual to accomplish ADLs, IADLs and health-related tasks. Providers for

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Remote Supports

Service Definition: Remote Supports is the provision of supports by staff at a remote location who are engaged with the individual through technology/devices with the capability for live two-way communication. Remote Support professionals will have the capacity to connect with the member through screen time or by phone, creating opportunities for social support, problem solving, and guidance. Remote supports will provide additional supports and will help decrease anxiety in members and will enhance monitoring of health concerns addressed in care plans. Additionally, this service will help individuals fully integrate into the community and participate in community activities by connecting individuals with family and friends more easily, by increasing individuals' engagements with outside opportunities like virtual programs through municipalities (senior centers, libraries, etc) and by giving individuals a degree of confidence with the backups. Remote supports will also allow the individual to control who and how their care is provided. By offering this service, members will be able to return home (from institutional stays) or remain in the community.

Equipment used to provide remote supports includes one or more of the following systems: motion sensing system, radio frequency identification, live video feed, live audio feed, GPS tracking, web-based monitoring system, or a device that otherwise meets the requirement for two-way communication. Individual interaction with the staff person may be scheduled, on-demand, or in response to an alert from a device in the remote support equipment system. The devices and monitors will be placed in the home based on the needs identified in the care planning assessment and tech provider assessment. Placement of video cameras in the bathroom will be prohibited. Placement of motion sensors in the bedroom or bathroom will be determined based on the care planning assessment for need. The use of camera or video equipment in the participants bedroom must address a complex medical need or other extreme circumstance as identified in the care planning assessment. The placement of video cameras or video equipment in the bedroom will only be justified if the consumer explicitly requests the use and is detailed in the care plan. The use of video monitoring is the exception rather than the rule in this program and can be utilized if wanted to monitor medical issues such as sleep disturbances or breathing issues overnight.

During the person-centered assessment and care plan development, the state will ensure that the member, involved family members and/or guardian agree to the use of remote supports and will document this approval through a risk agreement and informed consent. The participant will have complete control of the equipment if they so choose to. The sensors and video cameras that are utilized in the program are powered in the home and cannot be remotely turned on or off.
The technology can be turned off, unplugged, or disconnected from the internet at will. The participant and authorized representative will receive guidance on all the technology placed in the home during installation and have the option for triage and consultation when needed by the tech provider.

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The use of an intrusive device that signals the whereabouts or movements of an individual to ensure the safety of the individual or safety of the community, or a restriction that prevents an individual from having access to specific experiences, must always be reviewed and approved by the Department of Social Services. The methodology described above will meet HIPAA requirements and is accepted by DSS HIPAA compliance staff.

DSS will monitor the health and safety of its members and the appropriateness of remote supports during the initial person-centered assessment, care plan development and approval, status reviews, and annual reassessments. In addition, the specialized care manager will have monthly phone contact and bi-yearly in-home contact. This also includes ongoing monitoring and support from the remote provider to observe and document how the technology is doing as a support and ongoing assessment to see if the individual, staff and informal supports need additional training.

Remote supports includes a monthly equipment cost covered under assistive technology and a virtual support fee-for-service cost. Note that the equipment is already covered under the assistive technology service portion of this benefit. In order to provide remote live supports, the provider entity must be certified by the Department of Social Services as a community hub. The services are limited to additional services not otherwise covered under the state plan (outside of this section of the Medicaid state plan for 1915(i) CHCPE), including EPSDT, but consistent with 1915(i) CHCPE objectives of avoiding institutionalization.

Provider Qualifications: The provider must meet one of the following sets of qualifications:

Remote Support Provider. Must be certified as a Community Hub. In addition, the agency ensures that virtual support staff meet the following qualifications:
Prior to Employment:
·18 years of age
·criminal background check
·have ability to communicate effectively with the individual/family
·have ability to complete record keeping as required by the employer
Prior to being alone with the Individual:
·demonstrate competence in knowledge of DSS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies; prevention of sexual abuse; knowledge of approved and prohibited physical management techniques
·demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan

·demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
·ability to participate as a member of the team if requested by the individual
·demonstrate understanding of person-centered planning
· understand administration of medication

Homemaker Companion Plus Agency. Must be registered with the Department of Consumer Protection and also certified as Community Hub. In addition, homemaker companion agency is vendor of remote supports or subcontracts with a remote supports provider. The agency ensures that virtual support staff meet the following qualifications:
Prior to Employment:
·18 years of age
·criminal background check
·have ability to communicate effectively with the individual/family
·have ability to complete record keeping as required by the employer
Prior to being alone with the Individual:
·demonstrate competence in knowledge of DSS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies; prevention of sexual abuse; knowledge of approved and prohibited physical management techniques
·demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
·demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
·ability to participate as a member of the team if requested by the individual
·demonstrate understanding of person-centered planning
·understand administration of medication

Adult Day Plus Provider: Must have Certification required by the Adult Day Care Association of CT and must be certified as Community Hub. In addition, Adult Day provider is vendor of remote supports or subcontracts with a remote supports provider. The agency ensures that virtual support staff meet the following qualifications:
Prior to Employment:
·18 yrs of age
·criminal background check
·have ability to communicate effectively with the individual/family

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·have ability to complete record keeping as required by the employer
Prior to being alone with the Individual:
·demonstrate competence in knowledge of DSS policies and procedures: abuse/neglect; incident reporting; client rights and confidentiality; handling fire and other emergencies; prevention of sexual abuse; knowledge of approved and prohibited physical management techniques
·demonstrate competence/knowledge in topics required to safely support the individual as described in the Individual Plan
·demonstrate competence, skills, abilities, education and/or experience necessary to achieve the specific training outcomes as described in the Individual Plan
·ability to participate as a member of the team if requested by the individual
·demonstrate understanding of person-centered planning
· understand administration of medication

Limit on amount and scope: None

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D. Voluntary training on how to hire, manage or dismiss staff

Training

Service Definition: Training will be offered to participants via one-on-one (1:1) assistance or web-based training. 1:1 assistance will be fulfilled through a self-hired support and planning coach. The web-based option may be fulfilled through free online e-learning modules through the State of Connecticut Connect-Ability website or other on-line training programs.

Support and Planning Coach Qualifications:
• Be 21 years of age;
• have a completed criminal background check;
• have a completed registry check;
• demonstrate ability, experience and/or education to assist the individual and/or family in the hiring, management of personal care assistance and with other community services detailed in the participant's plan;
• demonstrate competence in knowledge of DSS policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques;
• demonstrate understanding of the role of the service, of advocacy, person-centered planning, and community services;
• demonstrate understanding of self-hiring protocols and DSS fiscal management policies;
• have certification as Aging and Disability Specialist or person centered planning certificate and continue to meet annual recertification in person centered planning requirements; and
• Other qualifications as determined by the participant.

Experience: Five years of experience in a professional capacity in a disability or health organization or five years of personal experience managing supports and services in the community either as a person with a disability or as a parent of a child with a disability, except that parents cannot provide this service for their own children. College training may be substituted for the General Experience on the basis of fifteen (15) semester hours equaling one half (1/2) of a year of experience to a maximum of four (4) years for a Bachelor's degree. A Master's degree in public health, social work, or rehabilitation may be substituted for General Experience.
Limit on amount and scope: This service is limited to an annual limit of $500 per participant.

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6. Home and Community-Based Services (HCBS) Setting

CFC services will be provided in residential settings that have been determined by the State to have met the home and community-based setting requirements outlined in 42 C.F.R. § 441.530. CFC residential settings include individual homes or apartments that meet CFC residential criteria.
CFC services are not available in any of the settings outlined in Section 1915(k)(1)(A)(ii) of the Social Security Act. These include nursing facilities, institutions for mental diseases, and intermediate care facilities for individuals with intellectual disabilities. In addition, CFC services are not available in group homes that serve individuals with developmental disabilities, group homes that serve people with psychiatric conditions, or assisted living environments. CFC services are also not provided in non-residential provider-owned or operated settings. These settings are explicitly excluded either because the state has determined that these settings do not meet the settings requirements in 42 CFR 441.530.

7. Assessment of Need– Who is conducting and frequency

A DSS nurse or social worker performs a level of care screening evaluation of each applicant. Level of Care will be met if the individual requires the level of care provided in a hospital, nursing facility, an intermediate care facility for individuals with intellectual disabilities (ICF/ID), an institution providing psychiatric services for individuals under 21, or an institution for mental diseases for individuals age 65 and older. Confirmation of a participant's level of care is determined by information gathered by assessors at contracted entities during initial assessment and annual re-assessment via face-to-face interviews utilizing the Universal Assessment (UA). Both assessment and re-assessment include a thorough evaluation of the client's individual circumstances. Although beneficial for the assessment to be conducted in person, to the extent clinically appropriate for each individual based on that person's circumstances, all or part of the assessment may be provided virtually, subject to the state's approval.
The UA is based on the InterRAI tool. The UA is a validation tool used to confirm level of care and calculate a level of need based on the identified needs of the participant. The UA assesses a participants Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) needs as well as taking into account their health, rehabilitation needs, and their natural supports.
Assessor qualifications: The assessor who conducts the assessments and provides ongoing monitoring is either a registered nurse (RN) licensed in Connecticut or a social services worker

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(3) Other Laboratory and X-ray Services –

- Laboratory Services: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of laboratory services. The agency's fee schedule rates were set as of ~~January 1~~May 12, 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." The Department reviews Medicare rate changes annually to ensure compliance with federal requirements.

- X-ray Services provided by independent radiology centers: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of x-ray services provided by independent radiology centers. The agency's fee schedule rates were set as of January 1, 2023. 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." Select the "Independent Radiology" fee schedule, which displays global fees, including both the technical and professional components of each fee.

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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 ~~April 1~~May 12, 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.

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, 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,

7. Home Health Services –

(a) Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area are provided with limitations.
(b) Home health aide services provided by a home health agency with limitations.
(c) Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility are provided with limitations.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of home health services provided by a home health agency listed above in (a), (b), and (c). The agency's fee schedule rates were set as of July 1, 2022 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.

Rate Increases and Supplemental Payments to Enhance, Expand, and/or Strengthen Home and Community-Based Services (HCBS), Implemented in accordance with the state's Spending Plan for Implementation of the American Rescue Plan Act of 2021, Section 9817, as updated (ARPA HCBS Spending Plan): General Requirements: All rate increases set forth below apply only to providers actively enrolled on the date payment is issued. As applicable, payments may be proportionally reduced to the extent necessary to remain within available funding approved under the ARPA HCBS Spending Plan.
In addition to the fee schedule rate, effective August 1, 2021, the state pays a value-based payment rate add-on of up to 1% of the applicable rate for any home health service set forth in (a), (b), and (c) above in accordance with the following:

The first 1% performance payment will be paid on or before March 31, 2022 and is effective for and based on expenditures from August 1, 2021 through February 28, 2022 for each qualifying provider that meets the following standards:
(a) Participation in the Department of Social Services Racial Equity Training – 80% of all supervisors employed by the agency must complete the first training by February 1, 2022; and,
(b) Provider has Data Sharing Agreement executed with the state's Health Information Exchange (HIE) Payment methodology.

The second 1% performance payment will be paid on or before July 31, 2022 and is effective for and based on expenditures from March 1, 2022 through June 30, 2022 for each qualifying provider that meets the following standards:
(a) Participation in Department of Social Services Racial Equity Training – 80% of all supervisors employed by the agency must complete the second training and 50% of all other staff employed by the agency must complete the first training; and,
(b) Signing, at a minimum, the HIE Empanelment Use Case; and,
(c) Action plan detailing how the provider sends their client roster in an approved format to the state's HIE.

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Home Health Services (Continued)

i. On or before July 31, 2023, benchmark payments will be paid to home health agency providers calculated based on 2% of expenditures from March 1, 2023 through June 30, 2023. Benchmarks must be met no later than June 15, 2023, and are as follows: (a) Participation in Department of Social Services' racial equity training and participation in related learning collaboratives; (b) Accessing and viewing data within the HIE and participation in data use learning collaboratives and training.

ii. On or before November 30, 2023, benchmark payments will be paid to home health agency providers effective for and calculated based on 2% of expenditures from July 1, 2023 through October 31, 2023. Benchmarks must be met no later than October 15, 2023, and are as follows: (a) Department of Social Services' racial equity training required component of all new staff orientation. Participation in related learning collaboratives; (b) Accessing and viewing data within the HIE and participation in data use learning collaboratives and training.

iii. Beginning with payments to be made on or before March 31, 2024, and every six months thereafter, payments will be paid to home health agency providers who meet the following outcomes: (a) Decrease in avoidable hospitalization; (b) Increase in percent of people who need ongoing services discharged from hospital to community in lieu of nursing home; and (c) Increase in probability of return to community within 100 days of nursing home admission. Payments are based on up to 2% of expenditures for the 6 months that immediately precede each payment (other than the first outcome payment which will be based on the 4 months that immediately precede the first payment). If the total cost of the 2% payout is less than total funds available, excess funds will be prorated up to a maximum limit of 4% and paid to providers who qualify for the outcome payment. This higher limit of 4% will be based on availability of funds as approved within the ARPA HCBS Spending Plan. Providers who meet all of the performance measures will receive a full payment. Providers who meet fewer than the maximum possible number of performance measures will receive a partial payment based on the number of performance measures that they meet, in which meeting each measure is associated with a pro rata equal share of the total payment for the provider.

(b) Quality Infrastructure Supplemental Payments

Payments will be made on or before July 31, 2023, November 30, 2023, and March 31, 2024 to home health agency providers who meet the benchmarks set forth below effective during and based on the greater of 5% of expenditures during the four calendar months that immediately precede the month in which the payment is made or $5,000. For purposes of determining the applicability of the $5,000 in lieu of the percentage, expenditures used as the basis of the payment are total HCBS expenditures for the provider across all programs. The following benchmarks apply and must be met no later than the first day of the month in

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Home Health Services (Continued)

which the payment is made: (a) Benchmark for July 2023 payment – Providers have met requirements to improve member service delivery documented and contracts in place with vendors to modify delivery system; providers have member satisfaction survey drafted; (b) Benchmark for November 2023 payment – Providers have delivery system modifications complete; (c) Benchmark for March 2024 payment – Providers have delivery system implemented and integrated into member service planning; member satisfaction survey complete.

(d) Medical supplies, equipment and appliances suitable for use in the home – Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of medical supplies, equipment and appliances suitable for use in the home. 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. Over-the-counter products provided by pharmacies are reimbursed at Average Wholesale Price (AWP).

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(d) 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.

Behavioral health services provided by medical clinics are moved to the Rehabilitative Services benefit category section of the Medicaid State Plan (42 CFR § 440.130(d))

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(e) Behavioral Health Clinics: (e.1) **Private Behavioral Health Clinics.** Services provided by behavioral health clinics are moved to the Rehabilitative Services benefit category section of the Medicaid State Plan (42 CFR § 440.130(d)).

~~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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(e.2) **Public Behavioral Health Clinics**. Services provided by behavioral health clinics are moved to the Rehabilitative Services benefit category section of the Medicaid State Plan (42 CFR § 440.130(d)).

~~Behavioral health clinic services pursuant to 42 C.F.R. § 440.90 as described in Attachments 3.1-A and Attachment 3.1-B and associated addendum pages are reimbursed by Medicaid when provided by the Department of Mental Health and Addiction Services (DMHAS) in a public behavioral health clinic to a Medicaid beneficiary and at least one outpatient behavioral health clinic service for that day is recorded for the beneficiary in the clinic. Reimbursement for private behavioral health clinics is described above. Documentation of services shall be maintained in the beneficiary's service record. Payment for outpatient services delivered by DMHAS in public behavioral health clinics may not duplicate Medicaid payments for other Medicaid covered services.~~

~~**1. Definitions applicable to this section:**~~

~~**1.1** Facility – a public behavioral health clinic where behavioral health clinic services are delivered as described in Attachment 3.1A and 3.1B. Each facility has its own NPI number.~~

~~**1.2** Rate Period – is the state fiscal year (SFY) beginning July 1 and ending June 30 of each year.~~

~~**1.3** Cost Report – CMS-approved Medicaid cost report for Public Outpatient clinic services.~~

~~**1.4** Reimbursable Cost – shall include salaries and wages, fringe benefits and indirect cost.~~

~~**1.5** Indirect Cost – indirect cost is calculated using the HHS approved indirect cost rate~~

~~**1.6** Unit of Service - outpatient behavioral health clinic services pursuant to 42 C.F.R. § 440.90 described in Attachments 3.1-A and 3.1-B and associated addendum pages.~~

~~**2. Interim Rates:**~~

~~Interim rates for outpatient services provided by DMHAS in public behavioral health clinics shall be updated annually. Interim rates for outpatient services in public behavioral health clinics~~

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~~will be computed using settled costs from the prior state fiscal year for public outpatient services provided to Medicaid clients in a public behavioral health clinic rounded up to the nearest $10. The cost reimbursement methodology is described below in section "4. Cost Reimbursement Methodology" and the timing of settlement is described below in section "5. Cost Settlement." Interim rates are provisional in nature, pending the completion of cost reconciliation and cost settlement for the rate period, as noted below in section "5. Cost Settlement." Payments for public outpatient services provided by DMHAS behavioral health clinics will not duplicate payments made under Medicaid for other covered services.~~

~~**3. Cost Reports:**~~

~~Final reimbursement for outpatient services provided by DMHAS in public behavioral health clinics is based on the certified by DMHAS cost report.~~

~~DMHAS shall complete and certify a cost report for outpatient services delivered by DMHAS in public behavioral health clinics during the previous State fiscal year. The reimbursable outpatient cost shall be determined in accordance with principles described in Medicare Provider Reimbursement Manual and OMB Circular A-87. Cost reports are due to the Department of Social Services no later than 10 months following the close of the State fiscal year during which the costs included in the cost report were incurred. The cost report shall include certification of funds by DMHAS. Submitted cost reports are subject to desk review by the Department of Social Services or its designee. Desk review shall be completed within 8 months following the receipt of cost reports.~~

~~**4. Cost Reimbursement Methodology:**~~

~~In determining Medicaid allowable costs for providing outpatient services delivered in public behavioral health clinics, the following elements shall be included and calculations shall be made:~~

~~**4.1** Subtotal direct cost net of physician costs shall include salary and wages and fringe benefits. Direct cost shall not include room and board charges.~~

~~**4.2** Adjusted subtotal direct costs net of physician costs removes any federal reimbursement from the Subtotal direct cost net of physician costs (item 4.1).~~

~~**4.3** Indirect cost shall be calculated by applying the HHS approved indirect cost rate for the cost reporting period to the adjusted subtotal direct costs net of physician costs (item 4.2).~~

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~~**4.4** Total costs net of physician costs is the sum of the adjusted subtotal direct costs net of physician costs (item 4.2) and the indirect cost applicable to direct cost (item 4.3).~~

~~**4.5** Outpatient program costs net of physician costs shall be calculated by applying outpatient allocation base, a result of the CMS approved RMTS, to the total direct cost net of physician costs (item 4.4).~~

~~**4.6** Medicaid penetration rate is the percent of Medicaid outpatient services of the total outpatient services recorded for the cost reporting period in DMHAS' WITS services report or its replacement.~~

~~**4.7** Medicaid allowable direct cost net of physician costs is the result of applying the Medicaid penetration rate (item 4.6) to the outpatient program cost net of physician costs (item 4.5).~~

~~**4.8** Medicaid allowable physician costs include salary and wages, fringe benefits, and indirect costs. It shall be calculated by multiplying the physician's reported hours of Medicaid visits and their hourly salary. Outpatient fringe benefits are calculated by taking their outpatient salary over their total annual salary, and applying the percentage to their fringe benefits. Physician indirect cost shall be calculated by applying the HHS approved indirect cost rate for the cost reporting period to sum of outpatient salary and fringe benefits.~~

~~**4.9** Medicaid allowable certified public expenditure (CPE) is the sum of the total Medicaid allowable direct cost net of physician costs (item 4.7) and the total Medicaid allowable physician cost (item 4.8).~~

~~**5. Cost Settlement:**~~

~~DMHAS claims paid at the interim rates for outpatient services delivered in public behavioral health clinics during the reporting period, as documented in the MMIS, will be compared to the total Medicaid allowable cost for outpatient services delivered in public behavioral health clinics based on the CMS approved cost report identified as per item (4). DMHAS interim rate claims for outpatient services delivered in public behavioral health clinics will be adjusted in aggregate. This results in cost reconciliation. Reconciliation will occur within 24 months of the end of the reporting period contained in the submitted cost report. If it has been determined that an overpayment has been made, the Department of Social Services will return the federal share of the overpayment. If the actual, certified Medicaid allowable costs of outpatient services delivered in public behavioral health clinics exceed the interim Medicaid rates, the Department of Social Services will submit claims to CMS for the underpayment. Cost settlement will occur within the~~

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~~timelines set forth in 42 CFR 433 Subpart F. Connecticut will not modify the CMS-approved scope of costs, time study methodology or the annual cost report methodology without CMS approval.~~

~~**6. Audit:**~~

~~All supporting accounting records, statistical data and all other records related to the provision of the outpatient services delivered by DMHAS in public behavioral health clinics is subject to audit. If an audit discloses discrepancies in the accuracy and/or allowances of actual direct or indirect costs or statistical data as submitted for each fiscal year by DMHAS, the Department of Social Services' Medicaid payment rate for the said period is subject to adjustment.~~

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(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.

Behavioral health services provided by rehabilitation clinics are moved to the Rehabilitative Services benefit category section of the Medicaid State Plan (42 CFR § 440.130(d)).

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Mental Services Provided by Clinics - Rehabilitative Services 42 CFR 440.130(d)

Mental Health Services Provided by Privately Operated Behavioral Health Clinics and Behavioral Health Services Provided by Medical Clinics and Rehabilitation Clinics. Except as otherwise noted in the Medicaid State Plan, the state-developed fee schedule is the same for both governmental and private providers. The agency's fee schedule rates for substance use disorder services in the rehabilitative services benefit category were set as of May 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 (for mental health services provided by behavioral health clinics, select the behavioral health clinic fee schedule and refer to the applicable codes as provided by freestanding clinics; for mental health services provided by medical clinics, select the medical clinic fee schedule and refer to the codes for mental health services; and for mental health services provided by rehabilitation clinics, select the rehabilitation clinic fee schedule and refer to the codes for mental health services;).

There is a separate fee schedule for private behavioral health clinics providing behavioral health services under the rehabilitative services benefit category 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

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Mental Services Provided by Clinics - Rehabilitative Services 42 CFR 440.130(d)

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).

Publicly Operated Behavioral Health Clinics. Behavioral health clinic services pursuant to 42 C.F.R. § 440.90 as described in Attachments 3.1-A and Attachment 3.1-B and associated addendum pages are reimbursed by Medicaid when provided by the Department of Mental Health and Addiction Services (DMHAS) in a public behavioral health clinic to a Medicaid beneficiary and at least one outpatient behavioral health clinic service for that day is recorded for the beneficiary in the clinic. Reimbursement for private behavioral health clinics is described above. Documentation of services shall be maintained in the beneficiary's service record. Payment for outpatient services delivered by DMHAS in public behavioral health clinics may not duplicate Medicaid payments for other Medicaid covered services.

1. Definitions applicable to this section:

1.1 Facility – a public behavioral health clinic where behavioral health clinic services are delivered as described in Attachment 3.1A and 3.1B. Each facility has its own NPI number.

1.2 Rate Period – is the state fiscal year (SFY) beginning July 1 and ending June 30 of each year.

1.3 Cost Report – CMS-approved Medicaid cost report for Public Outpatient clinic services.

1.4 Reimbursable Cost – shall include salaries and wages, fringe benefits and indirect cost.

1.5 Indirect Cost – indirect cost is calculated using the HHS approved indirect cost rate

1.6 Unit of Service - outpatient behavioral health clinic services pursuant to 42 C.F.R. § 440.90 described in Attachments 3.1-A and 3.1-B and associated addendum pages.

2. Interim Rates:

Interim rates for outpatient services provided by DMHAS in public behavioral health clinics shall be updated annually. Interim rates for outpatient services in public behavioral health clinics will be computed using settled costs from the prior state fiscal year for public outpatient services provided to Medicaid clients in a public behavioral health clinic rounded up to the nearest $10. The cost reimbursement methodology is described below in section "4. Cost Reimbursement Methodology" and the timing of settlement is described below in section "5. Cost Settlement."

Interim rates are provisional in nature, pending the completion of cost reconciliation and cost settlement for the rate period, as noted below in section "5. Cost Settlement." Payments for public outpatient services provided by DMHAS behavioral health clinics will not duplicate payments made under Medicaid for other covered services.

3. Cost Reports:
Final reimbursement for outpatient services provided by DMHAS in public behavioral health clinics is based on the certified by DMHAS cost report.
DMHAS shall complete and certify a cost report for outpatient services delivered by DMHAS in public behavioral health clinics during the previous State fiscal year. The reimbursable outpatient cost shall be determined in accordance with principles described in Medicare Provider Reimbursement Manual and OMB Circular A-87. Cost reports are due to the Department of Social Services no later than 10 months following the close of the State fiscal year during which the costs included in the cost report were incurred. The cost report shall include certification of funds by DMHAS. Submitted cost reports are subject to desk review by the Department of Social Services or its designee. Desk review shall be completed within 8 months following the receipt of cost reports.

4. Cost Reimbursement Methodology:
In determining Medicaid allowable costs for providing outpatient services delivered in public behavioral health clinics, the following elements shall be included and calculations shall be made:

4.1 Subtotal direct cost net of physician costs shall include salary and wages and fringe benefits. Direct cost shall not include room and board charges.
4.2 Adjusted subtotal direct costs net of physician costs removes any federal reimbursement from the Subtotal direct cost net of physician costs (item 4.1).
4.3 Indirect cost shall be calculated by applying the HHS approved indirect cost rate for the cost reporting period to the adjusted subtotal direct costs net of physician costs (item 4.2).
4.4 Total costs net of physician costs is the sum of the adjusted subtotal direct costs net of physician costs (item 4.2) and the indirect cost applicable to direct cost (item 4.3).
4.5 Outpatient program costs net of physician costs shall be calculated by applying outpatient allocation base, a result of the CMS approved RMTS, to the total direct cost net of physician costs (item 4.4).

4.6 Medicaid penetration rate is the percent of Medicaid outpatient services of the total outpatient services recorded for the cost reporting period in DMHAS' WITS services report or its replacement.
4.7 Medicaid allowable direct cost net of physician costs is the result of applying the Medicaid penetration rate (item 4.6) to the outpatient program cost net of physician costs (item 4.5).
4.8 Medicaid allowable physician costs include salary and wages, fringe benefits, and indirect costs. It shall be calculated by multiplying the physician's reported hours of Medicaid visits and their hourly salary. Outpatient fringe benefits are calculated by taking their outpatient salary over their total annual salary, and applying the percentage to their fringe benefits. Physician indirect cost shall be calculated by applying the HHS approved indirect cost rate for the cost reporting period to sum of outpatient salary and fringe benefits.
4.9 Medicaid allowable certified public expenditure (CPE) is the sum of the total Medicaid allowable direct cost net of physician costs (item 4.7) and the total Medicaid allowable physician cost (item 4.8).

5. Cost Settlement: DMHAS claims paid at the interim rates for outpatient services delivered in public behavioral health clinics during the reporting period, as documented in the MMIS, will be compared to the total Medicaid allowable cost for outpatient services delivered in public behavioral health clinics based on the CMS approved cost report identified as per item (4). DMHAS interim rate claims for outpatient services delivered in public behavioral health clinics will be adjusted in aggregate. This results in cost reconciliation. Reconciliation will occur within 24 months of the end of the reporting period contained in the submitted cost report. If it has been determined that an overpayment has been made, the Department of Social Services will return the federal share of the overpayment. If the actual, certified Medicaid allowable costs of outpatient services delivered in public behavioral health clinics exceed the interim Medicaid rates, the Department of Social Services will submit claims to CMS for the underpayment. Cost settlement will occur within the timelines set forth in 42 CFR 433 Subpart F. Connecticut will not modify the CMS-approved scope of costs, time study methodology or the annual cost report methodology without CMS approval.

6. Audit: All supporting accounting records, statistical data and all other records related to the provision of the outpatient services delivered by DMHAS in public behavioral health clinics is subject to audit. If an audit discloses discrepancies in the accuracy and/or allowances of actual direct or indirect costs or statistical data as submitted for each fiscal year by DMHAS, the Department of Social Services' Medicaid payment rate for the said period is subject to adjustment.

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Community First Choice State Plan Option Pursuant to Section 1915(k) of the Social Security Act

The payment methodology described below applies to all services and supports provided under Connecticut's Community First Choice (CFC) State Plan Option pursuant to section 1915(k) of the Social Security Act, as described in and provided in accordance with Attachment 3.1-K of the Medicaid State Plan.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of CFC services pursuant to section 1915(k) of the Social Security Act. Except as otherwise provided below, CFC services are paid pursuant to the current fee schedule for CFC. The agency's fee schedule rates were set as of May 12, 2023, 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. Medicaid payment under CFC does not include payment for room and board.

Payments are made by the Medicaid agency directly to the providers of State Plan services or to the fiscal intermediary to disperse payments. Payments for all State Plan services are made through the state's Medicaid Management Information System (MMIS).

As set forth on the fee schedule referenced above, the following CFC services are reimbursed as described below:

Attendant Care: Attendant care rates are billed under five distinct payment methodologies, each of which is based on the plan of care and the specific circumstances of the services provided, as follows:
1. Hourly Rate: When care is provided over a period of time which is neither live-in care for a continuous 24-hour period, nor a 12-hour overnight shift, a quarter-hour rate is used.
2. Per Diem Rate: When care is provided for a continuous 24-hour period by a live-in attendant, a per diem rate is billed, which assumes that the attendant receives at least eight hours of sleep, at least five of which is uninterrupted.
3. Pro-Rated Per Diem Rate: When the 24 hour shift is not completed; services are billed at a pro-rated per-diem rate.
4. Overnight Rate: When care is provided overnight for a 12-hour period, services are billed under an overnight rate, which assumes that the attendant sleeps for half of the hours.