**DEPARTMENT OF SOCIAL SERVICES**

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

**SPA 23-F: January 2023 HIPAA Compliance and Reimbursement Updates - Physician Services, Laboratory Services, Medical Equipment, Devices and Supplies (MEDS) / Durable Medical Equipment (DME), Adult and Children Dental Services, Independent Radiology**

The State of Connecticut Department of Social Services (DSS) proposes to submit the following Medicaid State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS).

**Changes to Medicaid State Plan**

Effective on or after January 1, 2023, SPA 23-F will amend Attachment 4.19-B of the Medicaid State Plan to make the updates to the payment methodologies for the categories of services described below.

First, this SPA will incorporate various January 2023 federal Healthcare Common Procedural Coding System (HCPCS) updates (additions, deletions and description changes) to the physician office and outpatient, physician-radiology, physician-surgery, independent radiology, MEDS, adult and children dental services, and laboratory fee schedules. Codes that are being added are being priced using a comparable methodology to other codes in the same or similar category. DSS is making these changes to ensure that these fee schedules remain compliant with the Health Insurance Portability and Accountability Act (HIPAA).

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

For procedure codes that are not priced on the January 2023 Medicare ASP Drug Pricing File and procedure codes that are described as “unclassified”, the drug will be priced at the lowest of:

* The usual and customary charge to the public or the actual submitted ingredient cost;
* The National Average Drug Acquisition Cost (NADAC) established by CMS;
* The Affordable Care Act Federal Upper Limit (FUL); or
* Wholesale Acquisition Cost (WAC) plus zero (0) percent when no NADAC is available for the specific drug.

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

Third, this SPA updates the rates for applicable long-acting reversible contraceptive (LARC) devices in order to ensure that the rate continues to align with the providers’ cost of obtaining the applicable device. Specifically, this SPA updates the LARC rate on the physician office and outpatient fee schedule for code J7300 Intraut copper contraceptive (Paragard) to $1,025.00.

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

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

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

Fifth, the following procedure codes are being added to the laboratory fee schedule in order to increase coverage for ovarian cancer testing and thereby improve public health and promote early detection for HUSKY Health members:

|  |  |  |
| --- | --- | --- |
| **Procedure Code** | **Description** | **Rate** |
| 81500 | Onco (ovar) two proteins | $182.35 |
| 81503 | Onco (ovar) five proteins | $627.90 |

Fee schedules are published at this link: <http://www.ctdssmap.com>, then select “Provider”, then select “Provider Fee Schedule Download” Accept or Decline the Terms and Conditions and go to the applicable fee schedule.

**Fiscal Impact**

DSS does not anticipate that the HIPAA compliant updates to the independent radiology, physician radiology, physician surgery, adult and children dental services and MEDS fee schedules will have any significant changes in annual aggregate expenditures.

The majority of the HIPAA compliant updates to the physician office and outpatient fee schedule are estimated to have little to no financial impact, since utilization of the added codes is likely to shift utilization from the deleted codes on the fee schedule. However, the cost estimate is entirely driven by the increase to the LARC procedure code described above which is expected to also have an offset savings driven by averted births. While averted births are not factored in that analysis, DSS estimates that this change will increase annual aggregate expenditures by approximately $69,222 in SFY 2023 and $171,116 in SFY 2024.

DSS estimates that updating the physician-administered drugs to the January 2023 Medicare ASP Drug Pricing File will increase aggregate expenditures by approximately $273,269 in SFY 2023 and $675,787 in SFY 2024.

DSS estimates that adding the CoCM codes will increase annual aggregate expenditures by approximately $912,474 in SFY 2023 and $3,007,513 in SFY 2024.

DSS estimates that the updates to the laboratory fee schedule will have minimal financial impact and will not change annual aggregate expenditures in SFY 2023 and SFY 2024.

**Obtaining SPA Language and Submitting Comments**

The proposed SPA is posted on the DSS website at this link: <https://portal.ct.gov/DSS/Health-And-Home-Care/Medicaid-State-Plan-Amendments>. The proposed SPA may also be obtained at any DSS field office, at the Town of Vernon Social Services Department, or upon request from DSS (see below).

To request a copy of the SPA from DSS or to send comments about the SPA, please email: [Public.Comment.DSS@ct.gov](file:///C%3A%5CUsers%5CHolmesN%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CTemporary%20Internet%20Files%5CContent.Outlook%5CI538MMOL%5CPublic.Comment.DSS%40ct.gov) or write to: Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105. Please reference “SPA 23-F: January 2023 HIPAA Compliance and Reimbursement Updates - Physician Services, Laboratory Services, Medical Equipment, Devices and Supplies (MEDS) / Durable Medical Equipment (DME), Adult and Children Dental Services, Independent Radiology”.

Anyone may send DSS written comments about this SPA. Written comments must be received by DSS at the above contact information no later than January 11, 2023.

**Addendum Page 11 to**

**Attachment 4.19-B Page 1**

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

**State Connecticut**

(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, 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.

TN # 23-F Approval Date Effective Date 01/01/2023

Supersedes

TN # 22-0035

**Attachment 4.19-B**

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

**State Connecticut**

**Home Health Services (Continued)**

(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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**Attachment 4.19-B**

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

**State: CONNECTICUT**

(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 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.

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.

1. 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,

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**Attachment 4.19-B**

**Page 1(e)**

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

**State Connecticut**

**Dental Services:**

(a) Dental Services Provided to Adults: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of dental services provided to adults. 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.

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

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