STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 24-A: January 2024 HIPAA Compliance and Reimbursement Updates

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.

<u>Changes to Medicaid State Plan</u>

Effective on or after January 1, 2024, SPA 24-A will amend Attachments 3.1-A, 3.1-B, and 4.19-B of the Medicaid State Plan to make the updates to the coverage language and payment methodologies described below.

First, this SPA will incorporate various January 2024 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, medical equipment devices and supplies (MEDS), adult and children dental services, laboratory, audiology/speech & language pathology, ambulatory surgical centers, rehabilitation clinic, medical clinic, and behavioral health clinic 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 the 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 2024 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 2024 Medicare ASP Drug Pricing File and procedure codes that are described as “unclassified”, as set forth in the existing approved payment methodology in the Medicaid State Plan, 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, this SPA will add periodontal Scaling & Root Planing (SRP) coverage and establish the rates for the Periodontal SRP services for children and adults as detailed below. The periodontal SRP codes will not be calculated into the Adult Benefit Maximum (ABM) established pursuant to section 17b-282c(a) of the Connecticut General Statutes because the codes will reimburse providers for services that are medically necessary as defined in section 17b-259b of the Connecticut General Statutes and therefore exempt from the ABM. The purpose of this change is to add coverage for periodontal SRP services, which are medically necessary dental services for Medicaid members, especially for those members who have comorbidity conditions that have been shown to be impacted negatively by periodontal disease.

Specifically, the following periodontal Current Dental Terminology (CDT) procedure codes are being added:

CDT Code	Description	Rates for Children and Adults
D0180	Comprehensive Periodontal Evaluation	$97.00
D4341	Periodontal SCRP Quadrant	$223.00
D4342	Periodontal SCRP; per 1 to 3 teeth	$129.00
D4355	Full Mouth Debridement	$153.00
D4910	Periodontal Maintenance	$138.00

Third, effective for dates of service on or after January 1, 2024, 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 code will be reimbursed separately from the encounter rate paid to federally qualified health centers (FQHCs). 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 code will be allowed to be billed and reimbursed as follows to FQHCs.

Procedure Codes	Description	Rates
G0512	Rural health clinic or federally qualified health center (RHC/FQHC) only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric COCM services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month.	$151.23

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

Fourth, pursuant to section 282 of Public Act 23-204, effective for the dates of service January 1, 2024, and forward, the reimbursement rates for adult (ages 19+) complex care skilled nursing services provided by home health agencies will be increased to equal the same rate for pediatric complex care skilled nursing services. The purpose of this change is to comply with this state law and to expand access to complex care skilled nursing services provided by home health agencies for adults.

Fifth, this SPA updates the rate for ParaGard, a long-acting reversible contraceptive (LARC) device 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 $1,085.00. The purpose of this change is to provide an updated rate that is sufficient to maintain access to this device.

Sixth, this SPA extends the following rate add-ons for pediatric inpatient psychiatric services currently approved in the Medicaid State Plan only through dates of service ending December 31, 2023. Specifically, this SPA extends the following rate add-ons, which are all currently in effect for another year, through December 31, 2024. Collectively, these rate add-ons are an interim voluntary value-based payment (VBP): (1) rate add-on to the applicable per diem rate for increasing bed capacity, utilization, and various reporting requirements that consists of a rate add-on to the applicable per diem rate, (2) an acuity-based add-on to the applicable per diem rate as authorized on a case-by-case basis, and (3) revision to the medically necessary discharge delay policy to provide reimbursement at the full per diem rate on a case-by-case basis. The purpose of these voluntary value-based payment opportunities is to help address the unmet need for pediatric inpatient psychiatric services and improve the quality of such services.

Lastly, this SPA implements the updates detailed below to the PCMH+ program, which is codified in the Medicaid State Plan as an Integrated Care Model within section 1905(a)(30) of the Social Security Act (Act), which is the Medicaid benefit category for "any other medical care, and any other type of remedial care recognized under State law, specified by the [HHS] Secretary." PCMH+ involves shared savings

payments and care coordination add-on payments for primary care case management (PCCM) services, as defined by section 1905(t) of the Act.

Under the language in the current Medicaid State Plan attachments noted above, in order to receive individual pool and challenge pool shared savings, each PCMH+ Participating Entity (PE) must improve on both the potentially preventable hospital admissions (PPA) and the potentially preventable hospital emergency department visits (PPV) compared to that PE's performance on each measure in the year prior to the performance year.

Each PE must continue to meet a quality gate for both the PPA and PPV measures. This SPA proposes to add flexibility to that requirement as detailed below. For each of the PPA and PPV measures, each PE must either: (1) be ranked within the top 30% of PEs for that measure in a performance year and/or (2) improve their score on that measure compared to the prior performance year. PEs will be eligible to qualify for shared savings payments for both the individual and challenge pools only if they meet at least one of these methods of meeting this updated quality gate for both PPA and PPV. All other requirements for potential eligibility for PCMH+ individual and challenge pools' shared savings payments continue to apply; the only change is to the quality gate for potential eligibility for such payments.

The purpose of the proposed change is to avoid penalizing PEs which have had consistent high performance on the PPA and/or PPV measures and to add necessary flexibility given the unpredictable nature of these measures given various unforeseeable impacts on such performance, such as new disease trends and other new reasons for higher than anticipated ED visits and/or hospital admissions unique to a performance year.

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

In aggregate, DSS anticipates that this SPA will increase annual aggregate expenditures by approximately $11,926,581 in State Fiscal Year (SFY) 2024 and $18,879,219 in SFY 2025.

DSS does not anticipate that the HIPAA compliant updates to the adult and children dental services, independent radiology, physician radiology, audiology/speech & language pathology services, rehabilitation clinics, and MEDS fee schedules will have any significant changes in annual aggregate expenditures.

The HIPAA update for the physician surgery fee schedule is estimated to have little to no financial impact, since utilization of the added codes is likely to shift utilization from existing codes on this fee

schedule. However, to be conservative, DSS estimates that this change may increase annual aggregate expenditures by approximately $6,307 in SFY 2024 and $15,591 in SFY 2025.

The HIPAA update for the ambulatory surgical center fee schedule is estimated to increase annual aggregate expenditures by approximately $59,240 in SFY 2024, and $146,441 in SFY 2025.

The HIPAA compliant updates to the physician office and outpatient fee schedule is estimated to decrease annual aggregate expenditures by approximately $110,300 in SFY 2024 and $272,660 in SFY 2025. Note that DSS is not reducing any rates associated with this SPA; this decrease in expenditures is anticipated because the federal government end-dated a particular billing code.

DSS estimates that updating the physician-administered drugs according to the January 2024 Medicare ASP Drug Pricing File will increase annual aggregate expenditures by approximately $1,254,865 in SFY 2024 and $3,102,027 in SFY 2025.

HIPAA updates for laboratory services are estimated to increase annual aggregate expenditures by approximately $2,777 in SFY 2024 and $6,765 in SFY 2025

DSS estimates that reimbursing FQHCs separately for CoCM services will increase annual aggregate expenditures by approximately $193,574 SFY 2024 and $478,516 in SFY 2025.

DSS estimates that the HIPAA updates and addition of a vaccine to the medical clinic fee schedule will result in increasing annual aggregate expenditures by approximately $937 in SFY 2024 and $1,614 in SFY 2025.

The proposed addition of periodontal services available to adult and children HUSKY Health members is estimated to increase annual aggregate expenditures by approximately $1,387,791 in SFY 2024 and $3,430,620 in SFY 2025.

It is anticipated that the changes to complex nursing care rates for home health services will increase annual aggregate expenditures by approximately $1,080,673 in SFY 2024 and $2,671,424 in SFY 2025.

The proposed rate increase to ParaGard is estimated to increase annual aggregate expenditures by approximately $29,557 in SFY 2024 and $73,066 in SFY 2025.

The extension of the pediatric inpatient psychiatric services is estimated to increase annual aggregate expenditures by approximately $7,800,560 in SFY 2024 and $8,677,495 in SFY 2025.

DSS does not anticipate that the PCMH+ updates described above will result in any significant changes in annual aggregate expenditures. Adding the specified flexibility to the quality gate for a PCMH+ PE to potentially receive shared savings payments may affect the internal distribution of shared savings payments within the cohort of PEs but is unlikely to change the total amount of shared savings payments.

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 resource center, at the Town of Vernon Social Services Department, or upon request from DSS (see below).

To request a copy of the SPA from DSS or to send comments about the SPA, please email: **Public.Comment.DSS@ct.gov** or write to: Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105. Please reference "SPA 24-A: January 2024 HIPAA Compliance and Reimbursement Updates".

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 10, 2024**.

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AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
CATEGORICALLY NEEDY GROUP(S): ALL

All Medicaid claim costs for covered services will be included in the shared savings calculations described in Attachment 4.19-B, except for: hospice; long-term services and supports (LTSS), including institutional and home and community-based services; and non-emergency medical transportation (NEMT) services. Participating Entities do not need to deliver all defined benefits; rather, the cost of all benefits provided to an assigned PCMH+ member, regardless of the specific provider that performed each service, will be included in the shared savings calculation.

III. Quality Measures

In addition to providing the Enhanced Care Coordination Activities (and for Participating Entities that are FQHCs, also the Care Coordination Add-On Payment Activities)
in order to be eligible to receive shared savings payments, if applicable, each PCMH+ Participating Entity must also maintain and/or improve the quality of care and care experience for beneficiaries assigned to the Participating Entity, as measured by various quality measures. Specifically, in order to be eligible to receive shared savings payments, each PCMH+ Participating Entity must meet specified standards, for quality measures as described in Attachment 4.19-B. The PCMH+ quality measure set contains process and outcome measures that include measures of beneficiary experience. Of those measures, a specified subset of measures will be used in calculating various payments, as described in Attachment 4.19-B. All of the quality measures and applicable and applicable quality gates have been updated as of January 1, 20214 and apply to payments and Performance Years beginning on or after that date and a description of those measures, including the use of each such measure in calculating shared savings payments, is posted to DSS's website at: https://portal.ct.gov/DSS/Health-And-Home-Care/PCMH-Plus/Quality-Measure, then select the applicable time period.

The quality measure set will be reviewed annually and updated as deemed necessary by DSS. Changes in the measure set will be derived from recommendations generated from the Program Evaluations for prior years.

IV.I. Measures to Prevent Under-Service

Participating Entities will be disqualified from receiving shared savings payments if they demonstrate repeated or systematic failure to offer medically necessary services or manipulate their member panel, whether or not there is evidence of intentionality. DSS uses a multi-pronged approach to identify and prevent under-service of PCMH+ members. The data points that DSS monitors under this approach include, but are not limited to: PCMH+ member grievances, provider performance on quality measures (particularly preventive care service measures),

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AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

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III. Quality Measures

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Pediatric Inpatient Psychiatric Services: Interim Rate-Add-Ons and Change to Medically Necessary Discharge Delay Reimbursement Methodology

Effective only for dates of service from December 1, 2021 through December 31, ~~2023~~2024, the following payment changes apply to: in-state psychiatric hospital and each of the following in-state hospitals with a pediatric inpatient psychiatric unit: short-term general hospitals, children's short-term general hospitals, and chronic disease hospitals (except that a chronic disease hospital is eligible either if it has a pediatric inpatient psychiatric unit or if it has a dedicated unit for providing specialized behavioral health services to children, including autism spectrum disorder services), plus border hospitals that meet the following: This rate add-on is also potentially available to border hospitals in accordance with the same conditions as in-state hospitals and that also must meet all of the following parameters: licensed short-term general hospital with a pediatric inpatient psychiatric unit or a private psychiatric hospital; located no more than 10 miles from the Connecticut border; and have no fewer than fifty episodes of pediatric inpatient psychiatric services paid by Connecticut Medicaid each year beginning in calendar year 2019 and continuing on an ongoing basis.

Each of the categories of hospitals listed above will be eligible for one or both of the following rate add-ons or change in reimbursement policy, as applicable and as set forth below for applicable pediatric inpatient psychiatric bed days. General hospitals and chronic disease hospitals are reimbursed for pediatric inpatient psychiatric services under the inpatient hospital benefit category set forth in section 1905(a)(1) of the Social Security Act. Psychiatric hospitals are reimbursed for pediatric inpatient psychiatric services under the inpatient psychiatric services for individuals under age 21 set forth in section 1905(a)(16) of the Social Security Act.

1. Rate Add-On for Increasing Access: Effective for dates of service from December 1, 2021 through December 31, ~~2023~~2024, each eligible hospital that increases the hospital's daily average number of pediatric inpatient psychiatric beds paid by Connecticut Medicaid for dates of service in each calendar quarter by 10% (rounded to the nearest whole number) or at least 2 beds, whichever is greater, compared to the daily average number of beds paid by Connecticut Medicaid for dates of service in the same calendar quarter in calendar year 2019 and complies with the other requirements set forth below may be eligible for this add-on. If a hospital's approved start date for this rate add-on is not the first day of a calendar quarter, then the calculation of minimum increase in bed days is the daily average number of pediatric inpatient psychiatric beds actually paid by Connecticut Medicaid from the start date through the end of the calendar quarter but is still compared to the average daily average number of beds paid by Connecticut Medicaid for dates of service in the same calendar quarter in calendar year 2019. Notwithstanding the previous two sentences, on a case-by-case basis, each hospital may submit a written request to DSS for an extraordinary circumstances' exception if it was unable to meet such thresholds due to extraordinary circumstance beyond its control. The hospital must also provide the state with real-time bed tracking, conduct post-discharge follow-up with each family, participate in the state's care transition and suicide prevention initiatives, and provide enhanced data reporting to the state. This rate add-on will be paid for all pediatric inpatient psychiatric bed days for each calendar quarter (including medically necessary discharge delay days) in which the hospital meets all of those requirements.

   The amount of this rate add-on is as follows:

a. For each eligible in-state non-governmental short-term general hospital that is currently paid in the first or second tier of the three tiered inpatient psychiatric per diem rate system, the add-on will be equivalent to transitioning to the current highest tier which will then increase by 2% each January 1st. This rate, incorporating the add-on, is as follows: calendar year 2021: $1,170.45; calendar year 2022: $1,193.86; calendar year 2023: $1,217.74
b. For each eligible border hospital and each eligible in-state children's general hospital and governmental short-term general hospital, the rate add-on will be equivalent to transitioning to the highest rate in the three-tiered system not incorporating any increases due to the 2019 settlement agreement with in-state non-governmental short-term general hospitals. This rate, incorporating the add-on, is $1,125.00.
c. Notwithstanding the above, any hospital that currently receives the highest inpatient psychiatric rate or a chronic disease hospital will receive a 10% rate add-on to the applicable rate.
d. For each eligible in-state psychiatric hospital, the rate add-on will be equivalent to transition to the highest rate in the three-tiered system during calendar year 2021. This rate, incorporating the add-on, is $1,170.45.

2. Rate Add-On for High Acuity: Effective for dates of service from December 1, 2021 through December 31, ~~2023~~2024, each eligible hospital will be paid a 10% rate add-on to the hospital's inpatient psychiatric per diem rate (in addition to the rate add-on under 1. above, if applicable) for the pediatric inpatient psychiatric bed days provided to each child whose behavior demonstrates acuity that requires additional support on the inpatient unit and is sufficiently acute that it interferes with the therapeutic participation or milieu on the inpatient unit of the child or other children based on the condition of the child. To receive this add-on, the state or its agent must approve the hospital's prior authorization request for this add-on which must include the hospital's documentation that the specified bed days meet the requirements of this paragraph.

3. Modification to Applicability of Medically Necessary Discharge Delay Rates: Effective for dates of service from December 1, 2021 through December 31, ~~2023~~2024, due to current high demand for inpatient services in conjunction with decreased capacity for non-inpatient services, the hospital will be paid the full applicable per diem rate, not the medically necessary discharge delay rate for applicable bed days when the individual no longer needs to remain in the inpatient setting but the state or its agent confirms as part of the authorization or concurrent review process that: the hospital has made and continues to make every attempt to secure the appropriate discharge plan that best meets the individual's needs; the discharge plan is appropriate but cannot be implemented for the applicable dates of service due to lack of availability of community-based services that are appropriate for the individual's discharge plan; and that active treatment is occurring in the hospital based on the individual's needs and meets medical necessity.

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(12) Effective January 1, 2024, the reimbursement for psychiatric collaborative of care services (CoCM), an integrated care to treat mental health conditions in medical settings, a select procedure code with an established rate will be paid to the medical federally qualified health center (FQHC) separately from the FQHC's prospective payment system (PPS) reimbursement. The agency's fee schedule rates were set as of January 1, 2024 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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(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 ~~May 12~~January 1, 2024~~3~~ 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.

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(3) Other Laboratory and X-ray Services (cont'd)

- 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, 20243. 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 ~~October~~ January 1, 2024~~3~~ 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,

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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 ~~May 12, 2023~~ January 1, 2024 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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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 ~~May 12, 2023~~January 1, 2024 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).

(b) Prosthetic devices

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of prosthetic devices. The agency's fee schedule rates were set as of January~~July~~ 1, 2024~~3~~ 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.

(c) Eyeglasses

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of eyeglasses. The agency's fee schedule rates were set as of July 1, 2008 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.

(d) Hearing Aids

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of hearing aids. The agency's fee schedule rates were set as of March 1, 2019 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. The price allowed for hearing aids shall be the actual acquisition cost of the hearing aid(s) to the provider, not to exceed the applicable rates on the Hearing Aid/Prosthetic Eye fee schedule.

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

(a) Ambulatory Surgical Centers: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of ambulatory surgical center services. The agency's fee schedule rates were set as of January 1, 20243 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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(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, 2024~~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.

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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 ~~May 12, 2023~~January 1, 2024 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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10. 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 ~~September 1, 2023~~January 1, 2024 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 ~~September 1, 2023~~January 1, 2024 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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11. Physical Therapy and Related Services (Physical Therapy, Occupational Therapy, Audiology and Speech and Language Pathology Services).

    a) Physical therapy and related services – Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of physical therapy and related services. The agency's fee schedule rates were set as of January 1, 2020 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.

    b) Occupational therapy – Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of occupational therapy services. The agency's fee schedule rates were set as of January 1, 2020 and are effective for services provided on or after that date. Occupational therapists will be reimbursed according to the fee schedule for physical therapists. 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.

    c) Audiology and speech and language pathology services – Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of audiology and speech and language pathology services. The agency's fee schedule rates were set as of January 1, 2024~~2~~ 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.

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 mental health services provided by privately operated behavioral health clinics and behavioral health services provided by medical clinics and rehabilitation clinics in the rehabilitative services benefit category were set as of ~~October~~ January 1, 202~~3~~4 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

TN # 24-A Approval Date ___________ Effective Date 01/01/2024
Supersedes
TN # 23-0022

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I. Shared Savings Payment Methodology: Individual Savings Pool and Quality Gates for Individual Savings Pool and Challenge Savings Pool

A. Individual Savings Pool Quality Measures and Quality Gates for Individual Savings Pool and Challenge Savings Pool

The quality measures and quality gates applicable to the payment methodology are described in Attachment 3.1-A and apply to payments made on or after the effective date of the applicable language. Specifically, iIn order to receive Individual Savings Pool or Challenge Pool shared savings payments, the Participating Entity must meet both of the following quality gates:

(1) Iimprove on its Total Quality Score. To determine eligibility for this quality gate, each Participating Entity's Individual Savings Pool Quality Measures are averaged for the Prior Year and Performance Year, with each measure receiving equal weighting. Each Participating Entity whose Performance Year average is greater than the Prior Year average becomes eligible to participate in the Challenge Pool.

(2) For each of the potentially preventable hospital admissions (PPA) and the potentially preventable hospital emergency department visits (PPV) measures, each PE must either: (A) be ranked within the top 30% of PEs for that measure in a performance year and/or (B) improve their score on that measure compared to the prior performance year. PEs will meet this quality gate only if they meet at least one of these methods of meeting this updated quality gate for both PPA and PPV.

B. Individual Savings Pool Total Quality Scoring

The Individual Savings Pool will be determined by the Participating Entity's Total Quality Score. The Total Quality Score will be developed based on the Participating Entity's quality scores (Absolute Quality) and improvement on quality scores (Improve Quality). Each quality measure can generate a maximum of two points - one point for the absolute level of quality achieved and one point for the year-over-year improvement in quality.

1. Absolute Quality: For each quality measure, a PCMH+ PE will earn a maximum of one point in accordance with the table below for its ability to reach Absolute Quality targets in the Performance Year. The 2020 Absolute Quality targets will be derived from the 75th percentile of all PCMH+ PE quality scores from 2018. The 2021 targets will be derived from the 75th percentile of all PCMH+ PE quality scores from 2019. These targets will be shared with each PE.

Quality Performance Measured Against Quality Target	Points Awarded
Between 0.00% and 74.99%	0.00
75.00% or greater	1.00

2. Improve Quality: For each quality measure, a PCMH+ PE will earn a maximum of one point in accordance with the table below based on its year-over-year improvement compared to the improvement for all of the PCMH+ Performing Entities. The table for each measure will be derived from all Performing Entities for each Performance Year.

Sharing Factor: If a Participating Entity has savings following the calculation steps above, these savings will be multiplied by a Sharing Factor of 50%. The resulting amount will form the Entity's Individual Savings Pool.

*Individual Savings Pool = Capped MSR Adj. Savings * 0.50*

D. Individual Savings Pool Shared Savings Calculation

For each Participating Entity, the Individual Savings Pool Shared Savings payment, if any, is equal to the Individual Savings Pool times the Total Individual Savings Pool Quality Score defined above.

*Individual Savings Pool Shared Savings = Individual Savings Pool * Total Quality Score*

II. Shared Savings Payment Methodology: Challenge Pool

A. Challenge Pool Eligibility

To be eligible for a Challenge Pool payment, a Participating Entity must meet the quality gates for the Individual Pool payment described above in this section.~~improve its overall performance year-over-year on the measures that apply to the Individual Savings Pool and improve year-over-year performance on the Avoidable ED Visits and Avoidable Hospitalizations quality measures. To determine eligibility, each Participating Entity's Individual Savings Pool Quality Measures are averaged for the Prior Year and Performance Year, with each measure receiving equal weighting. Each Participating Entity whose Performance Year average is greater than the Prior Year average becomes eligible to participate in the Challenge Pool.~~

B. Challenge Pool Funding

It is expected that one or more Participating Entities may not receive 100% of their Individual Savings Pool as shared savings payments because of less than perfect scores on the applicable quality measures or because DSS determined that the Participating Entity systematically engaged in under-service for Medicaid members. The amounts not returned will be aggregated to form a target amount for the Challenge Pool. The