STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 24-K: April 2024 HIPAA Compliance and Reimbursement Updates/ Updates to Person Centered Medical Homes/Human Breast Milk Donation/Addition of Select Laboratory Codes to the Family Planning Clinic Fee Schedule

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.

Changes to Medicaid State Plan

Effective on or after April 1, 2024, SPA 24-K will amend Attachment 4.19-B of the Medicaid State Plan to incorporate various April 2024 federal Healthcare Common Procedural Coding System (HCPCS) updates (additions, deletions, and description changes) to the physician office and outpatient medical equipment devices and supplies (MEDS), 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).

Secondly, SPA 24-K will amend Attachment 4.19-B of the Medicaid State Plan to update the list of procedure codes eligible for the Person-Centered Medical Home (PCMH) Program add-on payment. Several procedure codes billed under the PCMH program will no longer be eligible for the PCMH add-on payment effective March 31, 2024. Identified procedure codes that were end-dated because they were either no longer a valid billing code according to the federally recognized Current Procedural Terminology (CPT) manual or based on the description of the procedure code, were determined to no longer meet the eligibility criteria for the PCMH add-on payment. Additionally, select procedure codes for evaluation/management visits and depression screenings will be eligible for the PCMH add-on payment. For a complete list of eligible procedure codes for the PCMH add-on payment, please visit https://www.huskyhealthct.org/providers/PCMH/pcmh_postings/PCMH_Codes_Enhanced_Reimbursemnt.pdf. DSS is making these changes to ensure that eligible procedure codes are billable and complies with program eligibility.

Third, SPA 24-K will amend Attachment 4.19-B of the Medicaid State Plan to incorporate the addition of select laboratory procedure codes to the family planning clinic fee schedule, which will allow family planning clinics to implement respiratory tests for COVID-19 and Influenza. This changes is being implemented to expand access to these services.

Lastly, as required by Section 17b-277c of the Connecticut General Statutes, SPA 24-K will amend Attachment 4.19-B of the Medicaid State Plan to provide coverage of outpatient human donor breast milk for infants, under one year old, who are active on Connecticut Medicaid and meet medical necessity as defined by the clinical criteria established by DSS. Specifically, procedure code T2101 (human breast milk processing, storage, and distribution) will be added to the medical/surgical supplies fee schedule in order to allow coverage from enrolled milk banks accredited by the Human Milk Banking Association of North America (HMBANA). DSS is

making this changes to comply with state law referenced above and enable coverage of outpatient human donor breast milk.

Fee schedules are published at: http://www.ctdssmap.com. Select "Provider", then select "Provider Fee Schedule Download"; after accepting the terms and conditions, follow the prompts: Terms and Conditions, and go to the applicable fee schedule.

Fiscal Impact

The HIPAA 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 existing codes on the physician office & outpatient schedule. The deleted procedure codes had minimal paid amounts.

The HIPAA updates to the behavioral health clinic fee schedule are estimated to have little to no financial impact, since utilization of the added codes is likely to shift utilization from existing codes on the Behavioral Health Clinic schedule. The deleted procedure code, J0576-effective 1/1/24 through 3/31/24, had no paid amounts in SFY24 to date.

It is estimated that the HIPAA updates to Medical Equipment Devices and Supplies (MEDS) will increase annual aggregate expenditures by approximately $9,356 in SFY 2024, and $57,820 in SFY 2025.

It is estimated that the removal of select procedure codes and the addition of others to the eligibility for the PCMH Add-On payments will have a gross fiscal impact of $2,039 in SFY 2024, and $12,599 in SFY 2025.

It is anticipated that the addition of select laboratory codes to the family planning clinic fee schedule will increase Medicaid expenditures. The estimated gross increase in Medicaid program is $4,419 in SFY 2024, and $26,713 in SFY 2025.

DSS estimates that adding coverage of human donated breast milk is estimated to increase annual aggregate expenditures by approximately $59,400 in SFY 2024, and $364,420 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 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-K: April 2024 HIPAA Compliance and Reimbursement Updates/Updates to Person Centered Medical Homes/Human Breast Milk Donation/Addition of Select Laboratory Codes to the Family Planning Clinic Fee Schedule".

Anyone may send DSS written comments about this SPA. Written comments must be received by DSS at the above contact information no later than **April 10, 2024**.

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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 ~~February~~ April 1, ~~2024~~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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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, 99442, 99443, ~~D0145, D1206,~~ G8431and ~~99420~~ G8510.

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These codes were selected to pay providers for providing a more advanced level of primary care and to encourage more providers to provide primary care to beneficiaries, which will help expand access to primary care physicians' services. For a procedure provided to a beneficiary outside of the practitioner's office in a nursing facility, rest home, or the beneficiary's home, the applicable rate add-on will be paid if the beneficiary is attributed to the practitioner.

The base fees vary by practitioner type (physician, nurse practitioner, or physician assistant) according to the percentage of the physician fee schedule that is paid to each practitioner type. The rate add-on is paid at the same time as the underlying claim and is scaled based on the practice's stage of Glide Path or NCQA PCMH recognition:

i. For Glide Path practices, the total payment for each procedure code listed above, including the rate add-on, is 114% of the amount in the fee schedule.

ii. For NCQA Recognition Level 2, the total payment for each procedure code listed above, including the rate add-on, is 120% of the amount in the fee schedule.

iii. For NCQA Recognition Level 3, the total payment for each procedure code listed above, including the rate add-on, is 124% of the amount in the fee schedule.

Supplemental Payments for PCMH Practices: For PCMH practices only, the two types of supplemental payments detailed below will be paid to PCMH practices on a retrospective annualized basis based upon an attribution methodology, where recipients will be attributed to PCMH practices in accordance with the department's current written attribution methodology. The attribution methodology assigns recipients to primary care practitioners based on claims volume analyzed retrospectively every three calendar months. If a recipient receives care from multiple providers during a given period, the recipient is assigned to the practice that provided the plurality of care and if there is no single largest source of care, to the most recent source of care. Recipients may affirmatively select a PCMH practice as their primary care provider. After making a selection, regardless of the sources of care received prior to their selection during the period of claims measured in an attribution cycle, the recipient will be automatically attributed to their selected practice in the next attribution cycle. However, the recipient's selection will be overridden if, after making a selection, the recipient later receives more care from another practice in the same period of claims measured, although attribution is not changed if the recipient receives care from another practitioner within the same practice. Payments will be issued retrospectively in a lump sum on an annualized basis on or before December 31st for services provided in the previous calendar year (the "measurement year").

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Payment rates will not vary based on the practitioner type (physician, physician assistant, or nurse practitioner) to whom each recipient is attributed.

i. Supplemental Payment for Performance and Improvement: Independent physician groups, solo physicians, nurse practitioner groups, and individual nurse practitioners that meet all requirements for this supplemental payment will receive a payment totaling a maximum of the amount specified below for each member's enrollment month attributed to the practice. Payments will be issued retrospectively in a lump sum on an annualized basis on or before December 31st for services provided in the previous calendar year. The payment amount will be based on the practice's performance during the measurement year using the quality performance measures described in subsection (5)(c) below. PCMH practices are eligible for this payment only if they participate as a PCMH for the entire measurement year.

Performance Component: Each PCMH practice's performance on the quality performance measures are compared against all Medicaid-enrolled primary care practices that meet the minimum statistical thresholds for such measures and placed into percentiles, which are converted into points and averaged into a composite performance score. A practice earns 1 point for each measure where the rate is at or above the 75th percentile. A practice loses 1 point for each measure where the rate is at or below the 25th percentile. For measure rates that are between the 25th and 75th percentiles, the practice earns 0 points. Total earned performance points are then divided by the maximum possible earned points (i.e., the number of measures the practice qualified for) to yield the Performance Score.

Improvement Component: Each PCMH practice's earned points for improvement for each measure compared to the practice's rates from the previous year are calculated into a composite improvement score. A practice earns 1 point for each qualified measure where the rate for the current measurement year improved compared to the rate from the prior year. A practice loses 1 point for each qualified measure where the rate for the current measurement year worsened compared to the prior year rate. For rates that remain the same across both the measurement year and the year prior, the practice earns 0 points. Total earned improvement points are then divided by the maximum possible earned points (i.e., the number of measures the practice qualified for) to yield the Improvement Score.

Composite Score: Each qualified practice receives both the performance and improvement composite scores that range from -1 to 1. Those with high overall performance or high improvement receive higher scores (close to 1). Low performers and practices with no improvement receive lower scores (close to -1). The scored practices are plotted on the four-quadrant graph with performance on the Y axis and improvement on the X axis as shown in this graph:

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Composite Score: Each qualified practice receives both the performance and improvement composite scores that range from -1 to 1. Those with high overall performance or high improvement receive higher scores (close to 1). Low performers and practices with no improvement receive lower scores (close to -1). The scored practices are plotted on the four-quadrant graph with performance on the Y axis and improvement on the X axis as shown in this graph:

The levels of per member per month payment are as follows:

Performance Quadrant	**Supplemental Payment PMPM Amount**
Quadrant 4	No payment
Quadrant 3	$0.30 PMPM
Quadrant 2	$0.30 PMPM
Quadrant 1	$0.50 PMPM

Challenge Pool Supplemental Payment:
In addition to the Performance and Improvement Supplemental Payment described above, practices that are in the 90th percentile of performance on the challenge pool measures referenced in subsection (c) below will be eligible to receive a challenge pool supplemental payment. This payment is $0.20 per member month, paid in the same manner and timeframe as the Performance and Improvement Supplemental Payment.

(c) Quality Performance Measures for PCMH Program. The department's quality performance measures for the PCMH program are updated as of January 1, ~~2021~~2021, and are effective for quality payments made on or after that date. The quality performance measures can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. Select "Information", then select "Publications", then scroll down to the section regarding the PCMH program. The quality measures are used to measure PCMH practices' performance and their eligibility for certain payments that are described in the relevant section of the plan as being made or determined using these quality measures. These quality measures are based on improving quality, access, and care outcomes.

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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 ~~January~~ April 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).

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(c) Family Planning Clinics: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of family planning clinic services. The agency's fee schedule rates were set as of ~~February~~ April 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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(e) Behavioral Health Clinics: (e.1) **Private Behavioral Health Clinics.** Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of behavioral health clinic services. The agency's fee schedule rates for private behavioral health clinic services were set as of ~~January 1, 2023~~ April 1. 2024, 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).

(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~~ April 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.

(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.