

NOTICES OF CONNECTICUT STATE AGENCIES

DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 18-V: Updates to the Physician Office and Outpatient 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).

Changes to Medicaid State Plan

Effective on or after July 1, 2018, SPA 18-V will amend Attachment 4.19-B of the Medicaid State Plan to update the physician office and outpatient fee schedule as follows:

- Several procedure codes that are currently manually priced (specifically, codes 36482, 36482, 44381, 44381, 44384, 45388, 45388, 45389, 45390, 45393, 45398, 46601, 46601, 46607, 46607, 48551, 95875, 96377, 99091) will be priced at 57.5% of the 2018 Medicare physician fee schedule.
- The Federal Food & Drug Administration (FDA) approved Heplisav-B, a new Hepatitis-B vaccine to be administered to adults, aged 18 years and older. DSS will add Current Procedure Terminology (CPT) code: 90739-“Hepb vacc, 2 dose adult im”. It will be reimbursed at \$131.10, which is based on 100% of the April 2018 Medicare Average Sales Price (ASP) Drug Pricing File.
- Effective for dates of service July 1, 2018 and forward, DSS is increasing the reimbursement rate for the following LARC devices on the physician office and outpatient fee schedule as follows:

Code	Description	Price
J7296	Kyleena 19.5 mg	\$908.97
J7298	Mirena 52 mg	\$908.87
J7301	Skyla 13.5 mg	\$756.87
J7307	Etonogestrel implant	\$890.30

Additionally, the reimbursement rates for Kyleena, 19.5 mg (HCPCS code J7296) on the family planning clinic fee schedule will be increased to \$249.00, effective for dates of service July 1, 2018 and forward.

Reimbursement for LARC devices in the outpatient hospital setting will be determined by the specific HCPCS code billed for the LARC device inserted/placed. The reimbursement rate for LARC devices will be the rate published for the specified procedure code on the physician office and outpatient fee schedule or, for 340B hospitals, the family planning fee schedule.

Inpatient hospitals will be separately reimbursed for a LARC device provided immediately postpartum in the inpatient hospital setting when the LARC device is billed on an outpatient claim. The services related to the labor and delivery provided by the hospital will continue to be billed on the inpatient hospital claim and separate reimbursement for the LARC device will be made to the hospital in addition to the Diagnosis Related Group (DRG) reimbursement for labor and delivery.

- In order to allow HUSKY Health providers to be properly reimbursed for newly introduced, FDA approved vaccines/toxoids and timely access to medically necessary products, CPT code: 90749-“Unlisted vaccine/toxoid” will be added to the physician office & outpatient fee schedule, effective July 1, 2018. This CPT code should only be used when a specific CPT is currently not available for newly FDA approved vaccines/toxoids.

The pricing for the unlisted vaccines/toxoids will use the NDC as part of the pharmacy pricing methodology, specifically the lowest of (a) the usual and customary charge to the public or the pharmacy’s actual submitted ingredient cost; (b) the National Average Drug Acquisition Cost (NADAC) established by CMS; (c) the Affordable Care Act Federal Upper Limit (FUL); or (d) Wholesale Acquisition Cost (WAC) plus zero (0) percent when no NADAC is available for a specific drug.

Fee schedules are published at this link: <http://www.ctdssmap.com>, then select “Provider”, then select “Provider Fee Schedule Download.”

Fiscal Information

DSS estimates that this SPA will result in a gross increase in Medicaid expenditures of approximately \$333,000 in State Fiscal Year (SFY) 2019 and \$375,000 in SFY 2020.

Obtaining SPA Language and Submitting Comments

The proposed SPA is posted on the DSS website at this link: <http://portal.ct.gov/dss>. Scroll down to the bottom of the webpage and click on “Publications” and then click on “Updates.” Then click on “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 or write to: Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105 (Phone: 860-424-5067). Please reference “SPA 18-V: Updates to the Physician Office and Outpatient 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 July 11, 2018.

Department of Social Services**Notice of Proposed Medicaid State Plan Amendment (SPA)****SPA 18-W: Out-of-State Inpatient Hospital Rate Update**

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 August, 2018, as described below, SPA 18-W will amend Attachment 4.19-A of the Medicaid State Plan to modify the out-of-state inpatient hospital rate.

Specifically, the out-of-state all patient refined, diagnosis-related group (APR-DRG) base payment rate will be changed from \$7,855.63 to \$7,505.68 to reflect the documentation and coding improvement adjustment previously applied to all in-state hospital base payment rates. The SPA will remove reference to the statewide average rate and simply state the rates for DRG and per diem payments. The SPA will also clarify that the option of matching the home state rate is the DRG base rate without add-ons and that organ acquisition costs for transplants will be reimbursed in accordance with the home state Medicaid policy. Finally, it adds language to mirror the outpatient out-of-state hospital SPA concerning the negotiation of rates for services not available in Connecticut.

Fiscal Impact

DSS estimates that this SPA will decrease annual aggregate expenditures by approximately \$730,000 in SFY 2019 and \$800,000 in SFY 2020.

Compliance with Federal Access Regulations

In accordance with federal regulations at 42 C.F.R. §§ 447.203 and 447.204, DSS is required to ensure that there is sufficient access to Medicaid services, including services where payment rates are proposed to be reduced or where payment rates or methodologies are being restructured in a manner that may affect access to services. Those federal regulations also require DSS to have ongoing mechanisms for Medicaid members, providers, other stakeholders, and the public to provide DSS with feedback about access. In addition to other available procedures, anyone may send DSS comments about the potential impact of this SPA on access to hospital services as part of the public comment process for this SPA. Contact information and the deadline for submitting public comments are listed below.

Obtaining SPA Language and Submitting Comments

This SPA is posted on the DSS web site at this link: <http://portal.ct.gov/dss>. Scroll down to the bottom of the webpage and click on “Publications” and then click on “Updates.” Then click on “Medicaid State Plan Amendments”. The proposed SPA may also be obtained at any DSS field office or 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: Medical Policy Unit, Depart-

ment of Social Services, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105 (Phone: 860-424-5067). Please reference “SPA 18-W: Out-of-State Inpatient Hospital Rate Update”.

Anyone may send DSS written comments about the SPA. Written comments must be received by DSS at the above contact information no later than July 26, 2018.

DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 18-Y: Discontinue Coverage of Non-Surgical Birth Control Devices

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

Based on a recent sale restriction issued by the U.S. Food and Drug Administration (FDA), effective for dates of service on or after August 1, 2018, DSS will no longer cover non-surgical, non-hormonal implanted birth control devices or any similar device due to concerns about harmful medical side effects. Specifically, effective on or after August 1, 2018, this SPA will amend Attachment 4.19-B of the Medicaid State Plan to revise the physician-surgical, ambulatory surgical centers, and family planning clinics as described below (and any other reimbursement methodology that incorporates the physician fee schedule for these codes by reference, including Connecticut Medical Assistance Program outpatient hospital Addendum B).

The permanent implantable contraceptive intratubal occlusion device and delivery system that is used as part of bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants procedure will no longer be covered under the Healthcare Common Procedure Coding System (HCPCS) code A4264-Intratubal occlusion device. Other birth control devices such as the Falope ring and filshie clips remain covered and should continue to be billed under HCPCS code A4264.

Additionally, Current Procedure Terminology (CPT) code 58565-Hysteroscopy sterilization will be end-dated for dates of service, August 1, 2018 and forward on the following fee schedules to remove coverage of that service: physician-surgical, ambulatory surgical centers, and family planning clinics. The CPT code will be changed to a “no” under the payment type column on the Connecticut Medical Assistance Program Addendum B for outpatient hospitals.

Fee schedules are published at this link: <http://www.ctdssmap.com>, then select “Provider”, then select “Provider Fee Schedule Download.” This SPA is necessary in order to comply with federal requirements regarding the reimbursement for drugs provided in the settings described above.

Fiscal Information

DSS estimates that this SPA will result in a gross decrease in Medicaid expenditures of approximately \$20,000 in State Fiscal Year (SFY) 2019 and \$25,000 in SFY 2020.

Obtaining SPA Language and Submitting Comments

The proposed SPA is posted on the DSS website at this link: <http://portal.ct.gov/dss>. Scroll down to the bottom of the webpage and click on “Publications” and then click on “Updates.” Then click on “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 or write to: Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105 (Phone: 860-424-5067). Please reference “SPA 18-Y: Discontinue Coverage of Non-Surgical Birth Control Devices”.

Anyone may send DSS written comments about this SPA. Written comments must be received by DSS at the above contact information no later than July 26, 2018.

Attachment 4.19B
Page 1(a)i(E)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT **State: CONNECTICUT**

(5) Physician’s services – Fixed fee schedule not to exceed the Medicare physician fee schedule. The current fee schedule was set as of August 1, 2018 and is effective for services provided on or after that date. The fee schedule for physicians can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page, go to “Provider,” then to “Provider Fee Schedule Download.” All governmental and private providers are reimbursed according to the same 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 prac-

tioners 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, 99354, 99355, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99406, 99407, 99408, 99409, 99411, 99412, 99374, 99377, 99379, 99380, 96110, 99050, 99051, 99053, D0145,

TN # 18-Y Approval Date _____ Effective Date 08-01-2018
 Supersedes
 TN # 18-V

DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 18-X: Updates to CPAP and BiPAP Supplies

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 August 1, 2018, the Department of Social Services will begin allowing reimbursement of supplies used with Continuous Positive Airway Pressure (CPAP) and, Bi-Level Positive Airway Pressure (BiPAP) respiratory assist devices during the rental period of CPAP and BiPAP devices.

In order to enable that change, effective on or after August 1, 2018, SPA 18-X will amend Attachment 4.19-B of the Medicaid State Plan in order to reduce the reimbursement of the following supply codes used with CPAP and BiPAP devices:

Code	Description	New Fee
A4604	Tubing with integrated heating element for use with PAP device	\$39.97
A7027	Combination oral/nasal mask used with CPAP device	\$109.72
A7028	Oral cushion for combination oral/nasal mask, replacement only	\$32.05
A7029	Nasal pillows for combination oral/nasal mask, replacement only	\$15.00
A7030	Full face mask used with PAP device	\$88.49

A7031	Face mask interface, replacement for full face mask	\$33.36
A7032	Cushion for use on nasal mask interface, replacement only	\$18.61
A7033	Pillow for use on nasal cannula type interface, replacement only	\$15.35
A7034	Nasal interface used with PAP device	\$54.27
A7035	Headgear used with PAP device	\$18.56
A7036	Chinstrap used with PAP device	\$10.31
A7037	Tubing used with PAP device	\$11.61
A7038	Filter, disposable, used with PAP device	\$2.00
A7039	Filter, non-disposable used with PAP device	\$5.97
A7044	Oral interface used with PAP device	\$77.78
A7045	Exhalation port used with accessories for PAP device, replacement only	\$12.93
A7046	Water chamber for humidifier, used with PAP device, replacement only	\$12.31
E0561	Humidifier non-heated used with PAP device	\$68.30
E0562	Humidifier heated used with PAP device	\$132.83

Fees were developed using the lowest of the following:

- Current Medicaid rate, or;
- Medicare Fee Schedule rate, or;
- Average of the three Medicare Competitive Bidding Program rates for Connecticut.

For all procedure codes, the lowest rate was the average of the three Medicare Competitive Bidding Program rates. This rate change reflects a substantial reduction to these procedure codes.

Fee schedules are published at this link: <http://www.ctdssmap.com>, then select “Provider”, then select “Provider Fee Schedule Download.”

Fiscal Information

Based on available information and due to the variance in CPAP and BiPAP supplies that members may require during the rental period of the CPAP and BiPAP devices, the fiscal impact is unquantifiable. However, DSS estimates that the reduction in rates to the CPAP and BiPAP supplies will result in a substantial reduction of annual aggregate expenditures in both State Fiscal Year (SFY) 2019 and SFY 2020.

Compliance with Federal Access Regulations

In accordance with federal regulations at 42 C.F.R. §§ 447.203 and 447.204, DSS is required to ensure that there is sufficient access to Medicaid services, including

services where payment rates are proposed to be reduced. Those federal regulations also require DSS to have ongoing mechanisms for Medicaid members, providers, other stakeholders, and the public to provide DSS with feedback about access. In addition to other available procedures, anyone may send DSS comments about the potential impact of this SPA on access to medical equipment devices and supplies for which rates are being reduced or payment is being restructured in a manner that could affect access, as part of the public comment process for this SPA. Contact information and the deadline for submitting public comments are listed below.

Obtaining SPA Language and Submitting Comments

The proposed SPA is posted on the DSS website at this link: <http://portal.ct.gov/dss>. Scroll down to the bottom of the webpage and click on “Publications” and then click on “Updates.” Then click on “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 or write to: Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105 (Phone: 860-424-5067). Please reference “SPA 18-X: Updates to CPAP and BiPAP Supplies”.

Anyone may send DSS written comments about this SPA, including comments about access to the services for which this SPA proposes to reduce rates or restructure payments in a manner that could affect access. Written comments must be received by DSS at the above contact information no later than July 11, 2018.
