

## NOTICES OF CONNECTICUT STATE AGENCIES

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### PAID FAMILY & MEDICAL LEAVE INSURANCE AUTHORITY

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#### NOTICE OF INTENT TO ADOPT PROCEDURES RELATING THE APPLICATION TO UTILIZE A PRIVATE PLAN

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In accordance with sections 1-121 and 31-49o of the Connecticut General Statutes, notice is hereby given that the Board of Directors of the Connecticut Paid Family and Medical Leave Insurance Authority (“hereinafter the CT Paid Leave Authority”) intend to adopt the following procedures to be followed by employers seeking to apply to the CT Paid Leave Authority for approval to meet their obligations relating to the provision of paid leave insurance benefits for employees through a private plan.

All written comments regarding these procedures must be submitted by August 21, 2020 to the CT Paid Leave Authority via email at [PFMLIAComments@ct.gov](mailto:PFMLIAComments@ct.gov).

#### **Procedures for Employers to Apply for Approval to Utilize a Private Plan**

1. Employer registers with the CT Paid Leave Authority on the portal, providing or verifying employer’s name, address, contact information, industry code and total number of employees.
2. Employer completes the application for a private plan:
  - a. Employer specifies whether:
    - i. It has contracted with an insurer that has a Declaration of Insurance approved by the Connecticut Insurance Department (“hereinafter referred to as “CID”).
      - A. This option is available only during the period of time the CID accepts such Declarations, hereinafter referred to as the “interim period”);
    - ii. It has obtained coverage with an insurance with a CID-approved policy; or
    - iii. It is choosing to self-insure using a CID-approved self-insurance policy form.
  - b. The employer must produce a copy of the Declaration of Insurance (during the interim period only) or the policy. The CT Paid Leave Authority will verify with CID that the CID has approved the form of the declaration or the policy.
    - i. During the interim period, if the employer applies on the basis of a CID-approved Declaration of Insurance, the CT Paid Leave Authority may provisionally approve the private plan contingent upon the requirement that the employer must resubmit its application after the Declaration is replaced by a CID-approved policy and its employees have voted to approve the policy.
      - A. An employer who has received provisional approval from the CT Paid Leave Authority is exempted from the obligation to remit contributions.
      - B. Per the Notice To All Insurance Companies Authorized To Conduct Business In Connecticut Concerning Paid Family And Medical Leave Insurance, as part of Insurance Declaration process, the employer must acknowledge that if the policy is not

- in force on January 1, 2022, the employer will be responsible for contributions pursuant to Conn. Gen. Stat. § 31-49g, retroactive to January 1, 2021, and furthermore, that the employer may not collect retroactive contributions from covered employees to satisfy this requirement.
- ii. An employer that seeks a self-insurance option must furnish a bond running to the state in the form determined by the CT Paid Leave Authority and in the amount established by the CID.
  - iii. The CT Paid Leave Authority will approve an application for a self-insured private plan only if the employer's application demonstrates how it can administer claims in a sustainable and legally compliant manner, such as utilizing a Third Party Administrator or demonstrating that it has the capacity to administer the claims process in-house.
    - A. The CT Paid Leave Authority shall draft procedures detailing the factors it shall consider in its analysis of whether an employer has demonstrated that it can administer claims in a sustainability and legally compliant manner.
  - c. Employer provides documentation that the plan has been approved by a majority vote of its employees and that the vote complied with the CT Paid Leave Authority requirements:
    - i. "A majority vote of the employer's employees" means that at least 50% + 1 of the total number of employees employed by the employer voted in favor the plan.
      - A. It does **not** mean at least 50% + 1 of the number of employees who participated in the vote.
    - ii. During the interim period, if the employer applies on the basis of a CID- approved Declaration of Insurance, the CT Paid Leave Authority may provisionally approve the private plan contingent upon the requirement that the employer submits an updated application with documentation that it held a vote on the full CID-approved **policy**; the CID-approved policy was approved by a majority vote of its employees; and the vote complied with the CT Paid Leave Authority requirements.
    - iii. Requirements for the employee vote:
      - A. All employees on the employer's payroll as of the date of the vote, including full-time, part-time and probationary employees, as well as any regular employees who are on a paid or unpaid leaves of absence (such as vacation, medical, military, educational, disciplinary, etc.) on the day of the vote, shall be afforded the opportunity to vote.
      - B. The employer must provide the employees with a copy of the CID-approved insurance policy (or, during the interim period only, the CID-approved Declaration of Insurance) and instructions about the voting process at least two weeks before the vote commences.
      - C. The employer may provide additional information about the proposed policy, including information about any benefits provided that exceed the statutory requirements.
      - D. The employer shall not coerce or threaten the employees in any way in connection with the vote. Evidence that the employer engaged in any coercive or threatening behavior shall be grounds for the CT Paid Leave Authority to deny or revoke the private plan approval.

- E. The method of distribution of such documents must be at least as efficient and effective as the manner by which the employer distributes other legally required work-related postings, such as wage & hour, sexual harassment prevention, and workers' compensation information, and benefit information, such as pension/401k summary plan descriptions, open enrollment materials.
  - F. The employer must ensure that the documents are accessible to employees who are on leave.
  - G. The employer must ensure that the documents comply with federal and state requirements regarding disability accessibility and language accessibility.
  - H. The method of voting must be accessible to employees who are on leave.
  - I. The method of voting must comply with federal and state requirements regarding disability accessibility and language accessibility.
  - J. The question presented to the employees for the vote shall be: Do you approve the company's private plan to provide benefits required by the CT Paid Family and Medical Leave Insurance Act? Yes or No
  - K. The method of voting must be anonymous and must be capable of independent, after-the-fact verification.
    - The CT Paid Leave Authority strongly recommends that employers utilize electronic and/or on-line tools for voting provided the employer assures that all employees have access to such tools.
  - L. The employer shall submit documentary proof to the CT Paid Leave Authority that it complied with paragraphs 1 through 7 of this subsection with its application, including but not limited to, a description of the voting procedures, the total number of employees employed, the total number of employees who voted and the numbers of votes for and against the plan
  - M. Notwithstanding paragraphs 2 through 7 above, if an employer has entered into a collective bargaining agreement with its employers that dictates an alternative method of voting, the employer shall provide the CT Paid Leave Authority with a copy of the relevant collective bargaining agreement and documentation demonstrating its compliance with such agreement.
    - Nothing in this process shall diminish any rights provided to any employee or service worker under a collective bargaining agreement.
  - N. The CT PFMLIA shall have the authority to audit an employer's voting process for compliance with the statute and the Authority's requirements.
- d. The Employer shall attest that it will comply and will direct its insurer or Third Party Administrator (as applicable) to comply with the CT Paid Leave Authority's reporting requirements
- i. Such reporting requirements will include, but shall not be limited to, annual information on the following: the reasons claimants are receiving family and medical leave compensation, demographic information of claimants, including gender, age, town of residence

- and income level, and the total number of claims made and claims denied, and the reasons for any denials.
- ii. The CT Paid Leave Authority will establish reporting protocols to ensure that personally identifiable information and other confidential information are transmitted and maintained securely.
  - e. The Employer shall attest that it will comply and will direct its insurer or Third Party Administrator (as applicable) to comply with any the claims procedures adopted by the CT Paid Leave Authority.
  - f. The Employer shall attest that it will provide timely and complete responses and will direct its insurer or Third Party Administrator (as applicable) to provide timely and complete responses to any requests by the CT Paid Leave Authority, or its designee, for information relating to claims that the employer threatened or coerced employees in connection with the private plan vote; failed to pay benefits; failed to pay benefits timely and in a manner consistent with the public plan; failed to maintain an adequate security deposit as required by the CID; misused private plan funds; failed to submit reports as required; or failure to comply with sections 31-49e to 31-49t, inclusive of the Connecticut General Statutes.
3. The approval for a private plan shall be effective for one calendar year from the date the CT Paid Leave Authority notifies the employer that its private plan has been approved.
  4. The CT Paid Leave Authority may deny or withdraw approval for a private plan if the CT Paid Leave Authority determines that the employer has threatened or coerced employees in connection with the private plan vote; failed to pay benefits; failed to pay benefits timely and in a manner consistent with the public plan; failed to maintain an adequate security deposit as required by the CID; misused private plan funds; failed to submit reports as required; or failure to comply with sections 31-49e to 31-49t, inclusive of the Connecticut General Statutes or has directed its insurer or Third Party Administrator to engage in such actions.
    - a. The CT Paid Leave Authority shall draft procedures for determining if the denial or withdrawal of approval of a private plan is appropriate that it shall follow upon receipt of information that any of the above-listed events has occurred.
  5. The CT Paid Leave Authority may deny applications for a private plan option if it determines based upon actuarial principles that the solvency of the Trust may be jeopardized.
    - a. The CT Paid Leave Authority shall draft procedures for determining if the denial of approval of a private plan is appropriate based on concerns about the solvency of the Trust.
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**DEPARTMENT OF SOCIAL SERVICES****Notice of Proposed Medicaid State Plan Amendment (SPA)  
SPA 20-V: COVID-19 Coverage and Payment Updates  
After Federal Public Health Emergency**

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 25, 2020, SPA 20-V will amend Attachments 3.1-A, 3.1-B, 4.19-B, and 4.19-D of the Medicaid State Plan as described below.

The purpose of this SPA is to continue Medicaid coverage and payment for certain services related to the state's response to the Coronavirus Disease 2019 (COVID-19) pandemic that have been included in CT SPA 20-0015: COVID-19 Disaster Relief, which is the state's Medicaid disaster relief SPA for COVID-19. As a disaster relief SPA, 20-0015 will automatically end-date after the end of the federally declared public health emergency (PHE), including any extensions, so this SPA is necessary to continue certain changes after the end of the federal PHE. At the time this notice is being submitted for publication, the last day of the federal PHE is scheduled to be July 24, 2020. Although the federal government may renew the PHE declaration, at the time federal regulations require public notice to be published, it is not yet known if the federal PHE will be renewed. If the federal PHE is renewed, it is anticipated that the effective date of this SPA may be delayed until after the end of the federally declared PHE. For some of these, as specified below, the change will expire at the end of the state declared PHE, including any extensions. Fee schedules are published at this link: <http://www.ctdssmap.com>, then select "Provider", then select "Provider Fee Schedule Download", then Accept or Decline the Terms and Conditions and then select the applicable fee schedule.

**Telehealth Coverage and Payment**

New telehealth coverage pages will be added to Attachments 3.1-A and 3.1-B to provide that DSS covers telehealth to the extent authorized in its provider manual. Technical changes to existing SPA pages will also be made to remove any language that would otherwise prohibit telehealth coverage.

Effective through the end of the state PHE, Attachment 4.19-B will be amended to reflect that specific codes have been added to the physician and applicable clinic fee schedules to enable audio-only evaluation and management services to be provided by the following categories of providers: physician, physician assistants, advance practice registered nurses (APRNs), certified nurse-midwives, free-standing medical clinics, behavioral health clinics (including enhanced care clinics), outpatient hospital behavioral health clinics, public and private psychiatric outpatient hospital clinics, and family planning clinics fee schedules and may be billed by the providers as specified in the state's provider manual. These codes were set in a manner designed to approximate similar rates for equivalent in-person services, while accounting for differences in the time parameters associated with the in-person and audio-only codes.

Effective through the end of the state PHE, to the extent necessary and to the extent possible within available coding options, Attachment 4.19-B will be amended to enable audio-only psychotherapy to be provided by the following categories of providers: independent licensed behavioral health clinicians (licensed psychologists, licensed clinical social workers (LCSWs), licensed marital and family therapists (LMFTs), licensed professional counselors (LPCs), and licensed alcohol and drug counselors (LADCs)), behavioral health clinics (including enhanced care clinics), outpatient hospital behavioral health clinics, public and private psychiatric outpatient hospital clinics, free-standing medical clinics, rehabilitation clinics, behavioral health FQHCs, physicians, advanced practice registered nurses, and physician assistants. To the extent possible, these codes will be paid at the same rates as equivalent in-person services.

#### Laboratory Services Coverage and Payment

The laboratory coverage language in Attachments 3.1-A and 3.1-B will be updated to include the state's selection pursuant to 42 C.F.R. 440.30(d), to cover laboratory tests (including self-collected tests authorized by the FDA for home use) to diagnose or detect SARS-CoV-2, antibodies to SARS-CoV-2, or COVID-19 or the communicable disease named in the federal Public Health Emergency (PHE) as defined in 42 CFR 440.30(d) or its causes that do not meet one or more conditions specified in 42 CFR 440.30(a) and (b), because such coverage flexibility is intended to avoid transmission of COVID-19 or such other communicable disease. This coverage applies for the duration of any applicable Public Health Emergency and continues during any subsequent period of active surveillance, each as defined in 42 CFR 440.30(d).

In addition, Attachment 4.19-B will be amended to reflect that the laboratory (lab), medical clinic (MC), dialysis clinic (DC), and family planning clinic (FPC) fee schedules will be updated to add payment for specified codes related to testing of COVID-19 that have been added to the Medicare fee schedule. DSS anticipates continuing to have the following Healthcare Common Procedural Coding System (HCPCS) codes on the applicable fee schedules:

#### *Laboratory Fee Schedule:*

HCPCS Codes 87635, 86328, 86769, U0003, U0004, U0001, U0002, and 87426.

#### *Clinic Fee Schedules:*

<b>HCPCS Code</b>	<b>Fee Schedule(s)</b>
87635	DC, MC, FPC
U0001	DC, MC, FPC
U0002	DC, MC, FPC
U0003	FPC

From the end of the federally declared PHE until the end of the state declared PHE, these codes will be paid at 100% of the 2020 Medicare rate. After the state PHE ends, consistent with the reimbursement of other codes on the applicable fee schedule, the reimbursement methodology for the specified codes related to COVID-19 testing will be updated as follows: lab fee schedule will be paid at 70% of Medicare; MC and FPC fee schedules will be paid at 80% of Medicare; and DC fee schedule will be paid at 100% of Medicare.

#### Relaxing Requirements for Enhanced Care Clinics

Effective through the end of the state PHE, Attachment 4.19-B will be amended to reflect that the following requirements for the Enhanced Care Clinic higher payment rate for behavioral health clinics have been relaxed (no change in the rates, only relaxing the requirements for the provider to be eligible to receive the applicable rates):

- i. Suspending all specific time requirements for urgent or emergent cases;
- ii. Allowing clinics to temporarily merge sites to consolidate staff due to staffing shortages;
- iii. Suspending the state's Mystery Shopper calls; and
- iv. Waiving the requirement for extended operating hours.

#### Payment Changes to Accommodate Addition of Agency-Based PCA and Shelf-Stable Meals, and Emergency Meal Delivery Within the Community First Choice (CFC) Program Pursuant to Section 1915(k) of the Social Security Act and Other CFC Payment Changes

Effective through the end of the state PHE, Attachment 4.19-B will be amended to reflect that the payment methodology for CFC is modified as follows:

The state adds payment for agency-based PCAs as follows based on a fee schedule (no changes to the payment methodology for self-directed PCAs). The fee schedule is as follows:

Personal Care Services: Overnight Per Diem (12 Hour) Shift Agency: \$180.63

Personal Care Services: Per Diem (24 Hour) Agency: \$243.61

PCA Agency Per Diem Prorated Hourly: \$10.15

PCA Agency Overnight Prorated Hourly: \$15.05

PCA Agency 15 minute: \$4.92

Shelf-Stable Meals: Shelf-stable meals are paid at the following rates:

Meal Service Single Shelf-Stable Meal: \$6.50

Meal Service Double Shelf-Stable Meal: \$13.50

Kosher Meal Double Shelf-Stable Meal: \$13.50

Emergency meal delivery: Flat pick up rate of \$8.50 and \$1.75 per mile thereafter allocated equally across all participants receiving meals.

Nurse Health Coach: In order to maintain compliance with the Health Insurance Portability and Accountability Act (HIPAA), the following code is added to ensure continuity of coverage to replace a code that was removed from the Healthcare Common Procedural Coding System (HCPCS) national billing code set:

Registered Nurse Health Coach (HCPCS Code S5108): Max fee of \$23.80 per 15 minutes

#### Relaxing Requirement for Payment to Private Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Individual Leave Days

Effective through the end of the state PHE, Attachment 4.19-D is amended to reflect that individuals residing at the ICF/IID may exceed the standard home and hospital leave days and the state will pay the ICF/IID for those days without limit during the public health emergency. This change is necessary to ensure the ICF/IID is able to maintain their beds for when the individuals are able to return to the facility at the end of the public health emergency as well as facilitating individuals taking home leave in order to reduce the risk of COVID-19 spreading among the facility residents and staff.

### Random Moment Time Study (RMTS)/Time Study Flexibility

In certain situations in which the Medicaid State Plan provides for the use of RMTS in allocating costs for providers paid using a cost-based payment methodology, Attachment 4.19-B is amended to reflect the following flexibilities during the PHE to the extent that the state determines that such flexibility is necessary in order to appropriately reflect the disruptions in staffing, operations, and impact on members during the COVID-19 pandemic, including, as necessary, use of the RMTS average quarter results for the quarters ending December 31, 2020, March 31, 2021, and/or June 30, 2021, or such other quarter(s) as determined by the state, in place of the RMTS results for the quarter ending September 30, 2020 and any other applicable quarter(s) determined by the state. This flexibility applies to all such programs with RMTS in the Medicaid State Plan, including, but not limited to: behavioral health homes pursuant to section 1945 of the Social Security Act, targeted case management for individuals with chronic mental illness (TCM-CMI), Department of Mental Health and Addiction Services' publicly operated behavioral health clinics and outpatient hospitals, and TCM for individuals with intellectual disabilities (TCM-IID).

For private non-medical institution services (PNMI) for adults, the state plan will be modified to require only one time study in PNMI for adults, where two time studies are otherwise required each SFY.

Additionally, for the School Based Child Health program, the state plan will be modified to increase the oversample in developing the statistically valid sample size due to COVID-19 related issues in schools for the 2nd quarter of SFY 2021 and any other calendar quarter(s) determined by the state.

### **Fiscal Impact**

In general, DSS does not anticipate that this SPA will substantially change annual aggregate expenditures because these changes are broadly intended to enable continuity of coverage and payment during COVID-19 for services that would otherwise have been performed in accordance with parameters that were in effect prior to the PHE, as applicable. For the COVID-19 laboratory testing services, compared to the general Medicaid State Plan in effect prior to the PHE, based on information that is available at this time and subject to change in utilization over time, DSS estimates that those services will increase annual aggregate expenditures by approximately \$1.5 million.

### **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](mailto: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 20-V: COVID-19 Coverage and Payment Updates After Federal Public Health Emergency".

Anyone may send DSS written comments about this SPA. Written comments must be received by DSS at the above contact information no later than August 5, 2020.

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