NOTICE OF CONNECTICUT STATE AGENCIES

DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 23-E: Private Psychiatric Residential Treatment Facility (PRTF) Rate Increase

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

Changes to Medicaid State Plan

Effective on or after January 1, 2023, SPA 23-E will amend Attachment 4.19-A of the Medicaid State Plan to increase the per diem rate for private PRTFs to $792.46. This rate increase reflects the additional costs of each private PRTF adding director of nursing staffing, in which the director of nursing is on-site or available twenty-four hours per day, seven days per week in order to improve the quality and oversight of services provided by the PRTF.

In order to receive this rate, each PRTF must maintain this director of nursing staffing, in addition to all other applicable requirements, including the quality standards set forth in the Medicaid State Plan. The purpose of this SPA is to improve the quality of and access to the services of private PRTFs and to implement additional funding for PRTFs included in the budget adjustments to the state budget for State Fiscal Year (SFY) 2023 that were enacted by the General Assembly and signed by the Governor.

Fiscal Impact

DSS estimates that this SPA will increase annual aggregate expenditures by approximately $873,974 in State Fiscal Year (SFY) 2023 and $2,160,465 in SFY 2024.

Obtaining SPA Language and Submitting Comments

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

To request a copy of the SPA from DSS or to send comments about the SPA, please email: Public.Comment.DSS@ct.gov or write to: Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105. Please reference ''SPA 23-E: Private Psychiatric Residential Treatment Facility (PRTF) Rate Increase''.

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 26, 2023.

DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

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

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

Changes to Medicaid State Plan

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

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

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

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

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

In addition, in the existing approved Medicaid State Plan regarding the Medication-Administered Treatment (MAT) Benefit Category, the state assured coverage of Naltrexone, Buprenorphine, and Methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262). Consistent with that federally required and approved Medicaid State Plan methodology, the following procedure code will be added to the physician office and outpatient fee schedule: J0575

Buprenorphine/naloxone, oral, greater than 10 mg buprenorphine. This code is not currently on the January 2023 Medicare ASP drug pricing file; instead, it will be manually priced in accordance with the physician-administered drug reimbursement methodology described in the paragraph above for drugs not listed on the ASP pricing file.

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

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

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

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

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

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

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

Fiscal Impact

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

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

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

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

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

Obtaining SPA Language and Submitting Comments

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

To request a copy of the SPA from DSS or to send comments about the SPA, please email: Public.Comment.DSS@ct.gov or write to: Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105. Please reference ''SPA 23-F: January 2023 HIPAA Compliance and Reimbursement Updates - Physician Services, Laboratory Services, Medical Equipment, Devices and Supplies

(MEDS) / Durable Medical Equipment (DME), Adult and Children Dental Services, Independent Radiology''.

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

DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 23-G: Clinic Services – HIPAA Compliance Billing Code and Reimbursement Updates and Rate Increase for Children's Behavioral Health Home-Based Rehabilitation Services

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

Changes to Medicaid State Plan

Effective on or after January 1, 2023, SPA 23-G will amend Attachment 4.19-B of the Medicaid State Plan to revise various clinic fee schedules as detailed below.

First, this SPA updates the Dialysis Clinic and Ambulatory Surgical Center fee schedules to incorporate the 2023 Healthcare Common Procedural Coding System (HCPCS) changes (additions, deletions and description changes) to remain compliant with the Health Insurance Portability and Accountability Act (HIPAA). Codes that are being added are being priced using a comparable methodology to other codes in the same or similar category. For newly added codes that are replacing codes that are being deleted, they are being priced in a manner designed to be cost-neutral to the previous overall payment methodology.

Second, this update adds standardized cognitive performance testing (code 96125) and several procedure codes for cochlear implant analysis, programming and reprogramming services (codes 92626, 92627, 92601 through 92604) will be added to the Rehabilitation Clinic fee schedule, which are paid at 95% of 2023 Medicare rates, consistent with the overall reimbursement methodology for codes on that fee schedule. The purpose of adding the standardized cognitive performance testing code is to enable appropriate reimbursement for a key component of existing covered cognitive therapy services. The purpose of adding the cochlear implant analysis, programming and reprogramming services codes is to enable access to those services in the rehabilitation clinic setting and thereby improve overall access to these services.

Third, effective for the dates of service January 1, 2023 and forward, the Department will be adding two Pneumococcal conjugate vaccine procedure codes (90671 and 90677) to the Dialysis Clinic fee schedule, not part of the HIPAA compliance update, which are set in accordance with the physician-administered drug reimbursement methodology described below. The purpose of this change is to provide access to medically necessary vaccinations services for HUSKY Health members in the dialysis clinic setting.

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

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

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

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

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

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

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

Sixth, this SPA updates the rates for applicable long-acting reversible contraceptive (LARC) devices in order to ensure that the rate continues to align with the providers' cost of obtaining the applicable device. Specifically, the rate based on section 340B of the Public Health Services Act for the LARC device code J7300 Intraut copper contraceptive (ParaGard) will be updated to $297.57 on the family planning clinic fee schedule when provided by family planning clinics and Federally Qualified Health Centers (FQHCs).

Lastly, this SPA increases rates for children's behavioral health home-based rehabilitation services by 15%, which are provided by behavioral health clinics and are codes that are listed on the behavioral health clinic fee schedule. The purpose of this rate increase is to expand access to children's behavioral health home-based rehabilitation services for Medicaid members, especially youth with behavioral health conditions. Specifically, the following children's behavioral health home-based rehabilitation procedure codes are being increased:

Procedure Code	Description	Proposed Fee
H2019	Therapeutic behavioral health services	$22.49
H2019 HK	Therapeutic behavioral health services w/ modifier	$36.87
T1017	Targeted case management	$22.49
T1017 HK	Targeted case management w/ modifier	$36.87

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

Fiscal Impact

DSS estimates that the updates to the dialysis and ambulatory surgical center clinic fee schedules will not change annual aggregate expenditures in State Fiscal Year (SFY) 2023 and SFY 2024.

DSS estimates that the changes to the rehabilitation clinic fee schedule described above will increase annual aggregate expenditures by approximately $87,647 in SFY 2023 and $216,664 in SFY 2024.

DSS estimates that adding the CoCM codes to the medical clinic fee schedule will increase annual aggregate expenditures by approximately $152,079 in SFY 2023 and $501,252 in SFY 2024.

DSS estimates that collectively, the LARC device rate increase and the various physician-administered drug reimbursement updates described above (including the MAT code addition) will reduce annual aggregate expenditures by approximately $14,644 in SFY 2023 and $36,146 in SFY 2024. All physician-administered drug changes referenced above other than those added to the dialysis clinic fee schedule either had a small increase in projected annual aggregate expenditures or no change. As noted above, these reimbursement updates simply align with updates to federal drug pricing files or methodologies as required by the existing approved Medicaid State Plan.

DSS estimates that increasing the rates for behavioral health home-based rehabilitation services will increase annual aggregate expenditures by approximately $1,110,417 in SFY 2023 and $2,691,650 in SFY 2024.

Obtaining SPA Language and Submitting Comments

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

To request a copy of the SPA from DSS or to send comments about the SPA, please email: Public.Comment.DSS@ct.gov or write to: Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105. Please reference ''SPA 23-G: Clinic Services – HIPAA Compliance Billing Code and

Reimbursement Updates and Rate Increase for Children's Behavioral Health Home-Based Rehabilitation Services''.

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

DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 23-L: Community First Choice – January 2023 Rate Increase to Implement Personal Care Attendant Collective Bargaining Agreement

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 January 1, 2023, this SPA will amend Attachment 4.19-B of the Medicaid State Plan to increase the minimum rate for self-directed personal care attendant (PCA) services for Community First Choice (CFC) pursuant to section 1915(k) of the Social Security Act as detailed below. The purpose of this SPA is to update the Medicaid state plan for CFC as required by the collective bargaining agreement between the state and the union representing PCAs, which was updated by an agreement ratified by the Connecticut General Assembly on May 3, 2022. Specifically, as required by the amended collective bargaining agreement, the minimum hourly wage for self-directed PCAs effective January 1, 2023 is $18.25, which, after factoring additional components of the rate required to be incorporated based on the approved Medicaid State Plan, results in a rate of $6.58 per 15-minute unit for self-directed PCA services. This rate increase is in addition to the various reimbursement changes already incorporated into approved SPA 22-0034.

Fiscal Impact

DSS estimates that this SPA will increase annual aggregate expenditures by approximately $2,690,720 in State Fiscal Year (SFY) 2023 and $7,103,500 in SFY 2024.

Obtaining SPA Language and Submitting Comments

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

To request a copy of the SPA from DSS or to send comments about the SPA, please email: Public.Comment.DSS@ct.gov or write to: Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105. Please reference ''SPA 23-L: Community First Choice – January 2023 Rate Increase to Implement Personal Care Attendant Collective Bargaining Agreement''.

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 26, 2023.

DEPARTMENT OF SOCIAL SERVICES

Notice of Intent to Submit Emergency Preparedness and Response Amendments (Appendix K) to the Department's 1915(c) Home and Community-Based Services Medicaid Waivers

In accordance with the provisions of section 17b-8 of the Connecticut General Statutes, notice is hereby given that the Commissioner of the Department of Social Services (''DSS'' or the ''Department'') intends to submit two Emergency Preparedness and Response Amendments (''Appendix K amendments'') related to certain of the Department's 1915(c) home and community-based services (HCBS) Medicaid waivers.

The Appendix K amendments are temporary and expire six months following the expiration of the Federal public health emergency related to the continued consequences of the Coronavirus Disease (COVID-19) pandemic. The amendments are additive to the previously approved Appendix Ks. The following is a summary of the proposed changes, as more-fully described in the Appendix K amendments.

I. The Department is proposing temporary increases in provider payment rates for the following 1915(c) HCBS Medicaid waivers:

- Home and Community Based Services Waiver for Elders
- Personal Care Assistance Waiver
- Acquired Brain Injury Waiver
- Acquired Brain Injury Waiver II
- Home and Community Supports Waiver for Persons with Autism
- Mental Health Waiver
- Katie Beckett Waiver

The temporary provider rates, as more fully described in the Appendix K, include the following:

A. Supplemental rate funding for value-based payment (VBP) increased from 1% to 2% VBP as approved under the ARPA reinvestment plan, effective 7/1/2022, with the VBP increase contingent on: participation in race-equity training; connection to the state's health information exchange (HIE); and reporting of quality and financial data.

B. Supplemental rate funding for certain improvements in meaningful use of data.

II. The Department is proposing to temporarily modify services on the following 1915(c) HCBS Medicaid waivers:

- Home and Community Based Services Waiver for Elders
- Personal Care Assistance Waiver
- Acquired Brain Injury Waiver
- Acquired Brain Injury Waiver II
- Home and Community Supports Waiver for Persons with Autism

The temporary service changes, as more fully described in the Appendix K, include the following:

A. Addition of Remote Support as a new service. The service definition includes the following:

''Remote supports'' means the provision of supports by staff at a remote location who are engaged with the individual through technology/devices with the capability for live two-way communication. Equipment used to meet this requirement must include one or more of the following systems: motion sensing system, radio frequency identification, live video feed, live audio feed, GPS tracking, web-based monitoring system, or a device that otherwise meets the requirement for two-way communication. Individual interaction with the staff person may be scheduled, on-demand, or in response to an alert from a device in the remote support equipment system.

The use of an intrusive device that signals the whereabouts or movements of an individual to ensure the safety of the individual or safety of the community, or a restriction that prevents an individual from having access to specific experiences, must always be reviewed and approved by DSS.

Remote supports include a monthly equipment cost covered under assistive technology and a virtual support fee-for-service cost.

Remote supports may not be provided at the same time as any other direct support service nor at the same time as adult day, assisted living, adult family living, respite or personal emergency response.

B. Addition of new provider types, as well as new rate for on-call personal care attendant services and remote live personal care attendant service during the duration of this Appendix K. New providers of personal care attendant services include adult day providers and remote support providers as further defined in the Appendix K. Provider types are updated to include providers who are certified community hubs.

C. The definition of assistive technology is modified to specifically reference remote equipment and the associated requirements for internet access.

A complete text of the Appendix K amendments are available, at no cost, upon request to the Community Options Unit, Department of Social Services, 55 Farmington Ave., Hartford, Connecticut 06105; or via email to Jennifer.Cavallaro@ct.gov. It is also available on the Department's website, www.ct.gov/dss, under ''News and Press,'' as well as the following direct link: http://portal.ct.gov/DSS/Health-And-Home-Care/Medicaid-Waiver-Applications/Medicaid-Waiver-Applications. In addition, it is also available on the Department of Mental Health and Addiction Services (DMHAS) website, www.ct.gov/dmhas, under ''What's New!'' as well as the following link: https://portal.ct.gov/DMHAS/Programs-and-Services/Mental-Health-Waiver/Mental-Health-Waiver.

Any written comments must be submitted by **January 27, 2023** to the Department of Social Services, Community Options Unit, 55 Farmington Ave, Hartford, CT 06105, Attention: Jennifer Cavallaro, Director; or via email to Jennifer.Cavallaro@ct.gov.

DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 23-H: COVID-19 Disaster Relief SPA – Rate Increases and Coverage Additions for Community First Choice (CFC) Under Section 1915(k) of the Social Security Act and State Plan Home and Community-Based Services (HCBS) Options Under Section 1915(i) of the Social Security Act for HCBS Services for Older Adults and Connecticut Housing Engagement and Support Services (CHESS)

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 the dates set forth below, this COVID-19 disaster relief SPA will amend Section 7.4-A of the Medicaid State Plan to add the provisions detailed below. This disaster relief SPA is governed by the flexibility in standard federal requirements implemented by CMS and pursuant to the state's approved waiver from CMS pursuant to section 1135 of the Social Security Act during the federally declared national emergency and public health emergency to help assist with the state's response to the COVID-19 pandemic and its effects. In accordance with federal flexibility requirements, this COVID-19 disaster relief SPA will sunset no later than the last day of the federally declared COVID-19 public health emergency, as extended. This flexibility is available only for SPAs that increase access to services, increase rates, or provide other flexibilities designed to expand access to Medicaid services.

The purpose of the provisions of this SPA described in item 1 below is to implement relevant provisions of the state's Spending Plan for Implementation of the American Rescue Plan Act (ARPA) of 2021, Section 9817, as updated (ARPA HCBS Spending Plan). In addition, consistent with that plan and the applicable federal statute and CMS guidance, the rate increases and service expansions included in this SPA will help address the COVID-19 pandemic and its effects by enabling the specified HCBS providers to recruit and retain qualified staff, help address staffing shortages worsened by COVID-19, and recognize additional costs and burdens resulting from COVID-19 and its effects.

The purpose of the provisions of this SPA described in item 2 below is to reflect that providers of specified section 1915(i) HCBS for elders have increased costs in paying higher wages to certain staff in order to comply with the July 1, 2022 increase in the state's minimum wage.

1. ARPA HCBS Rate Increases and Service Expansions

All rate increases set forth below apply only to providers actively enrolled on the date payment is issued. Providers and services excluded from these rate increases for 1915(i) HCBS for Older Adults are: Assistive Technology; Environmental Accessibility Modifications, Personal Response Systems, Skilled Chore, Specialized Medical Equipment, Individual Goods and Services, and all Self-Directed Services. The only CFC providers eligible to receive these rate increases are providers of agency-

based support and planning coach services. As applicable, payments may be proportionally reduced to the extent necessary to remain within available funding approved under the ARPA HCBS Spending Plan.

A. Rate Increase for CHESS 1915(i)

Effective August 16, 2021, the rates for CHESS care plan development and monitoring, pre-tenancy supports, and tenancy sustaining supports increase by 3.5% and, if the provider meets the requirements set forth below, one or more additional performance payments detailed below.

B. Value-Based Payment Supplemental Payments for 1915(i) HCBS for Older Adults, 1915(i) CHESS, and CFC Agency-Based Support and Planning Coach Services

CHESS providers who meet applicable benchmarks set forth in the SPA pages (which are the same benchmarks that applied to the other eligible providers for prior payment periods through and including the payment for those providers in November 2022) will be eligible to receive a performance payment to be made on or before March 31, 2023 calculated based on 1% of applicable expenditures from August 16, 2021 through October 31, 2022.

Applicable 1915(i) HCBS for Older Adults and CFC providers will be eligible to receive payments applicable for November 2022 (calculated based on 1% of expenditures for the prior four months), so long as the provider meets applicable benchmarks set forth in the SPA pages, which include, as applicable, standards related to training, surveys, and health information exchange participation.

There will be payments for March 2023, July 2023, and November 2023 for applicable CHESS, 1915(i) HCBS for Older Adults, and CFC providers, who will be eligible for receive payments calculated based on 2% of expenditures for the prior four months, so long as the provider meets the benchmarks set forth in the SPA pages, which include, as applicable, standards related to training, surveys, and health information exchange participation.

Beginning in March 2024, for applicable CHESS, 1915(i) HCBS for Older Adults, and CFC providers, the value-based payment will change from the progressive benchmark payments to outcome-based payments with outcome measures set forth in the SPA pages related to decreasing avoidable hospitalization, increasing percent of people who need ongoing services discharged from hospital to community in lieu of nursing home, and increase in probability of return to community within 90 days of nursing home admission. Payments are based on up to 2% of expenditures for the 6 months that immediately precede each payment other than the first outcome payment which will be based on the 4 months that immediately precede the first payment.

C. Provider Quality Infrastructure Supplemental Payments for 1915(i) HCBS for Older Adults, 1915(i) CHESS, and CFC Agency-Based Support and Planning Coach Services

Eligible 1915(i) HCBS for Older Adults, 1915(i) CHESS, and CFC providers will receive benchmark payments in each of March, July, and November 2023 based on the greater of 5% of expenditures from the four months prior to the payment or $5,000 based on the provider meeting phase 1, phase 2, and phase 3 benchmarks, respectively, of delivery system quality infrastructure improvements detailed in the SPA pages.

D. Service Expansions

Effective on or after July 1, 2022 or as otherwise specified in the SPA pages, this SPA will make the following service expansions:

i. For Section 1915(i) HCBS for Older Adults – Remote Live Supports: This SPA adds Remote Live Support as a new service in the section 1915(i) HCBS for Older Adults benefit. This service is defined in more detail in the SPA pages and includes the provision of supports by staff at a remote location who are engaged with the individual through technology/devices with the capability for live two-way communication. Individual interaction with the staff person may be scheduled, on-demand, or in response to an alert from a device in the remote support equipment system. Note that the equipment is already covered under the assistive technology service portion of this benefit. In order to provide remote live supports, the provider entity must be certified by DSS as a community hub.

ii. For Section 1915(i) HCBS for Older Adults – Additional Rate: Addition of new rate of $52.89 for emergency back-up personal care attendant services.

iii. For both 1915(i) HCBS for Older Adults, 1915(i) CHESS, and 1915(k) CFC – Updated Definition of Assistive Technology: The definition of assistive technology is modified to specifically reference remote equipment and the associated requirements for internet access.

2. Minimum Wage Rate Increase for Section 1915(i) Portion of HCBS for Older Adults

Effective from July 1, 2022 through September 30, 2022 this SPA will amend Section 7.4-A of the Medicaid State Plan to increase the rates by 5.2% for the following Healthcare Common Procedure Coding System (HCPCS) codes within the state plan home and community-based services option under section 1915(i) of the Social Security Act portion of the Connecticut Home Care Program for Elders (CHCPE): 1021Z, 1022Z, 1023Z, 1200Z, 1201Z, 1202Z, 1206Z, 1210Z, 1213M, 1213M, 1214Z, 1225Z, 1226Z, 1228Z, 1230Z, 1232Z, 1244Z, 1430Z, 1431Z, 1432Z, 1433Z, 1434Z, 3022Z, 3024Z, 3025Z, 3026Z, 3027Z, 3027Z, and 3028Z. Note that this rate increase was already added to the Medicaid State Plan effective October 1, 2022 by approved SPA 22-0032.

Fiscal Impact

DSS estimates that this SPA will increase annual aggregate expenditures by approximately $287,668 in State Fiscal Year (SFY) 2023 and $406,949 in SFY 2024.

Obtaining SPA Language and Submitting Comments

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

To request a copy of the SPA from DSS or to send comments about the SPA, please email: Public.Comment.DSS@ct.gov or write to: Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105. Please reference ''SPA 23-H: COVID-19 Disaster Relief SPA – Rate Increases and Coverage Additions for Community First Choice (CFC) Under Section 1915(k) of the Social Security Act and State Plan Home and Community-Based Services (HCBS)

Options Under Section 1915(i) of the Social Security Act for HCBS Services for Older Adults and Connecticut Housing Engagement and Support Services (CHESS)''.

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 27, 2023**.