NOTICE OF CONNECTICUT STATE AGENCIES

DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 23-U: Coverage and Payment Modifications for the Transition from the Coronavirus Disease 2019 (COVID-19) Federal Public Health Emergency (PHE)

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.

Proposed Changes to Medicaid State Plan

Effective on or after May 12, 2023, which is the first day after the scheduled end of the federal Coronavirus Disease 2019 (COVID-19) public health emergency (PHE), this SPA will Attachments 3.1-A, 3.1-B, 3.1-K, and 4.19-B of the Medicaid State Plan to make the updates detailed below. Fee schedules are published at this link: https://www.ctdssmap.com, then select ''Provider'', then select ''Provider Fee Schedule Download,'' then select the applicable fee schedule. Whenever fee schedules are referenced, they incorporate the fee schedule rates for the applicable dates as posted on the fee schedule accessible from that webpage.

As explained in more detail below in the context of each proposed change included in this SPA, the overall purpose of this SPA is to continue certain flexibility under various approved disaster relief SPAs and submitted proposed disaster relief SPA 23-0005, which are 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 PHE to help assist with the state's response to the COVID-19 pandemic and its effects. In accordance with federal requirements, all COVID-19 disaster relief SPAs will sunset no later than the last day of the federal PHE, which, as communicated by the federal government, will be May 11, 2023.

Home Health Services Reimbursement. There will be payments made in July 2023, November 2023, and March 2024 for qualifying home health agency 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. For six-month periods after March 2024, 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.

The purpose of this portion of the SPA is to continue implementing, with respect to home health services, relevant provisions of the state's Spending Plan for Implementation of the American Rescue Plan Act (ARPA) of 2021, Section 9817, as updated, which relates to Home and Community-Based Services (HCBS) (ARPA HCBS Spending Plan). The purpose of the ARPA HCBS Spending Plan, in turn, is to improve the quality, access, and infrastructure for HCBS, as defined in that federal law and associated CMS guidance.

Community First Choice (CFC) Coverage and Reimbursement.

CFC Provisions Related to ARPA HCBS Spending Plan

Also consistent with implementing relevant provisions of the ARPA HCBS Spending Plan in improving access, quality and infrastructure for HCBS, this SPA makes the following coverage and reimbursement expansions. This SPA adds remote supports, which 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. This SPA also expands the coverage definition of assistive technology to specifically reference remote equipment.

Note that other SPA provisions related to CFC for implementation of the ARPA HCBS Spending Plan are included in proposed SPA 23-0005-A (as are similar provisions related to the section 1915(i) Connecticut Home Care Program for Elders (CHCPE) and the section 1915(i) Connecticut Housing Engagement and Support Services (CHESS)).

CFC Provisions Continuing Certain Disaster Relief SPA Flexibilities

This SPA continues the following flexibilities for the Community First Choice (CFC) benefit pursuant to section 1915(k) of the Social Security Act included in one or more approved disaster relief SPAs:

- First, although beneficial for care planning and service delivery for the attendant care category of service to be provided in person whenever feasible, to the extent clinically appropriate for each individual based on that person's circumstances, care planning and service delivery for attending care services may be continued to be provided virtually, subject to the state's approval on a case-by-case basis.
- Second, the provider qualifications for providers of agency-based support and planning coach services are broadened to enable, as a substitute for five years of experience in a professional capacity in a disability or health organization, to also allow five years of personal experience managing supports and services in the community either as a person with a disability or as a parent of a child with a disability, except that parents cannot provide this service for their own children. All other relevant qualifications remain in effect.
- Third, although beneficial for the assessment to be conducted in person, to the extent clinically appropriate for each individual based on that person's circumstances, all or part of the assessment may be provided virtually, subject to the state's approval on a case-by-case basis.

The purpose of the proposed change described above is to maintain virtual options for access to those relevant services when clinically appropriate to help improve choice and access for CFC participants.

Moving Clinic Mental Health Services to the Rehabilitation Services Benefit Category. In guidance issued by CMS earlier in the PHE, CMS detailed that it interprets the federal clinic regulation (42 C.F.R. § 440.90) to require that for telehealth to be billed by a clinic within the clinic Medicaid State Plan benefit category, either the clinic's practitioner or the member must be located in a licensed location of the clinic. During the PHE, the state requested, and CMS approved, a disaster relief waiver under section 1135 of the Social Security Act allowing the state to cover telehealth services provided by a clinic even if neither the practitioner nor the member was located in a licensed location of that clinic. That section 1135 waiver will expire automatically at the end of the federal PHE. The purpose of this portion of the SPA is to enable the state to have the flexibility to cover mental health services provided by a clinic via telehealth when neither the clinic practitioner nor the member is in a licensed location of the clinic. Note that this flexibility is still subject to the broader DSS telehealth policy regarding requirements and procedures for telehealth, which this SPA is not changing.

In order to enable continuation of this flexibility, this portion of the SPA will move mental health services provided by behavioral health clinics, medical clinics, and rehabilitation clinics from the federal Medicaid State Plan clinic benefit category defined by federal regulation at 42 C.F.R. § 440.90 to the federal Medicaid State Plan rehabilitative services benefit category defined by federal regulation at 42 C.F.R. § 440.130(d). This change will apply both to privately operated clinics and to public clinics operated by the State of Connecticut Department of Mental Health and Addiction Services (DMHAS). This change applies only to mental health services and only to freestanding behavioral health clinics, medical clinics, and rehabilitation clinics currently enrolled with DSS as clinic provider types. This change does not apply to federally qualified health centers (FQHCs) or outpatient hospitals because those federal regulations are more flexible in this context and do not include the restrictions on telehealth that CMS has interpreted to the clinic regulation, as referenced above. This change also does not apply to substance use disorder (SUD) services, because those services were previously moved to the federal Medicaid State Plan rehabilitation services benefit category through approved SPA 22-0020, which was coordinated with the state's approved SUD demonstration waiver pursuant to section 1115 of the Social Security Act.

This SPA does not make any substantive changes to coverage or reimbursement in this context, simply moving existing covered services and reimbursement methodology from the federal clinic benefit category to the federal rehabilitation services benefit category. Rates, reimbursement methodology, and coverage all remain the same. The purpose of this change is set forth above to maintain the state's ability to cover telehealth in the context as described above.

Removing Restrictive Language for Audio-Only Services and Reimbursement for Specified Covered Audio-Only Services. In order to enable the state to continue covering telehealth services, including where applicable and covered in accordance with DSS policy, audio-only services, this SPA removes language in the coverage pages for the physician services benefit category that currently indicates that services provided over the telephone are not covered. Related, this SPA also reflects the addition of audio-only billing codes to the physician office and outpatient fee schedule, which were previously added by one or more approved COVID disaster

relief SPAs, which expire automatically at the end of the PHE. Specifically, the following codes are added:

Procedure Code	Description	Rate
99442	Physician telephone patient service, 11-20 minutes of medical discussion	$42.93
99443	Physician telephone patient service, 21-30 minutes of medical discussion	$64.99

Laboratory Coverage Flexibility. In order to maintain access to COVID-19 laboratory settings, this SPA continues the state's election of the laboratory flexibilities authorized in federal regulation under 42 C.F.R. § 440.30(d), which were made in one or more approved disaster relief SPAs, which are expiring at the end of the PHE. Specifically, in accordance with that regulation through the end of the PHE and period of active surveillance as defined in that regulation, the state chooses to cover COVID-19 laboratory testing or other testing for such other infectious disease named in a future federal PHE (1) without a physician's order and (2) in places of service (POS) other than an office or laboratory location, which can allow pop-up testing sites and other non-traditional locations for testing.

The purpose of this change is to maintain access to COVID-19 tests and to promote public health.

COVID-19 Vaccine Reimbursement. Consistent with approved SPA 22-0013 and continuing the reimbursement that was in effect through one or more approved disaster relief SPAs, this SPA continues the current reimbursement methodology for COVID-19 vaccine administration and vaccines for pharmacy providers and for the applicable fee schedules (physician (when provided by physicians, nurse practitioners, physician assistants, and certified nurse-midwives and for this service, all of those practitioners will be paid at 100% of the fee on the physician fee schedule), home health agency (regardless of whether the beneficiary is otherwise receiving home health services), hospice agency (regardless of whether the beneficiary is otherwise receiving hospice services), medical clinic, dialysis clinic, and family planning clinic) to be 100% of Medicare from dates of service May 12, 2023 through September 30, 2024.

Additionally, for dates of service May 12, 2023 through September 30, 2024, this SPA will reimburse the COVID-19 vaccine product, when commercially purchased, at 100% of the Medicare rate, or in the absence of a Medicare rate, in accordance with the federally approved Medicaid State Plan provisions regarding physician-administered drugs, 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 the Centers for Medicare and Medicaid Services;
- 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.

COVID-19 vaccine administration and vaccine product will be reimbursed to the following providers: Physicians, Physician Assistants, Advanced Practice Registered Nurses, Certified Nurse Midwives, Medical Clinics, Family Planning Clinics, Dialysis Clinics, Federally Qualified Health Centers, Outpatient Hospitals, Hospice Agencies, Home Health Agencies, Dentists, and Pharmacies.

The state will review the reimbursement level for dates of service October 1, 2024 forward at a future time and in a future SPA.

The purpose of this change is to maintain access to COVID-19 vaccine administration and vaccines.

COVID-19 Testing Reimbursement. Finally, consistent with approved SPA 22-0013 and continuing the reimbursement that was in effect through one or more approved disaster relief SPAs this SPA will update COVID-19 testing reimbursement rates for dates of service May 12, 2023-September 30, 2024. This update is to continue to allow payment of COVID lab tests to be reimbursed at 100% of current Medicare rates during that time frame, which applies to the independent laboratory, physician, dialysis clinic, family planning clinic, and medical clinic fee schedules. The state will review the reimbursement level for dates of service October 1, 2024 forward at a future time and in a future SPA, reflecting in part the consideration that the laboratory fee schedule is generally set at 70% of Medicare rates.

Estimated Fiscal Impact

Home Health. DSS estimates that the home health reimbursement increases will increase annual aggregate expenditures by approximately $3,334,942 in SFY 2023, $7,665,854 in SFY 2024, and $2,816,476 in SFY 2025.

Removing Restrictive Language for Physician Services Performed via Audio-Only. DSS estimates that removing the restrictions on coverage for audio-only services and maintaining the reimbursement for the audio-only procedure codes set forth above will increase annual aggregate expenditures by approximately $943,528 in SFY 2023, $971,834 in SFY 2024 and $1,000,989 in SFY 2025.

CFC. DSS does not anticipate any significant fiscal impact from the portions of this SPA that extend specified provisions from the approved disaster relief SPAs because those pieces simply provide more flexibility in terms of the mode of accessing the service or in the qualifications of providers, as applicable, but they do not change actual coverage or reimbursement. DSS estimates that the ARPA HCBS CFC coverage and reimbursement expansions will increase annual aggregate expenditures by approximately $30,000 in SFY 2023, $218,822 in SFY 2024 and $693,346 in SFY 2025.

Mental Health Services in Clinics. DSS does not anticipate any significant fiscal impact from the portion of this SPA that moves mental health services provided by freestanding clinics from the federal clinic benefit category to the federal rehabilitation services benefit category because the substantive coverage and reimbursement are not changing.

Laboratory Coverage Flexibility. At this time, DSS does not anticipate any significant fiscal impact from the portion of this SPA that continues the flexibility to cover COVID-19 laboratory tests without a physician order and/or in a setting other than laboratory or office. However, if it were ever to become necessary to expand COVID-19 testing in those contexts back to peak pandemic levels, then continuing this flexibility would be associated with approximately $1,000,000 in monthly gross expenditures (or annualized to approximately $12,000,000 in annual aggregate expenditures).

COVID-19 Testing Reimbursement. DSS estimates that the portion of this SPA maintaining reimbursement at 100% of Medicare for COVID-19 testing for the May 12, 2023 through September 30, 2024 period is likely to result in increasing annual aggregate expenditures by approximately $2,315,110 in SFY 2023, $20,666,213 in SFY 2024 and $5,321,550 in SFY 2025.

COVID-19 Vaccines and Vaccine Administration Reimbursement. DSS estimates that the portion of this SPA maintaining reimbursement at 100% of Medicare for COVID-19 vaccines and vaccine administration for the May 12, 2023 through September 30, 2024 period is likely to result in increasing annual aggregate expenditures by approximately $13,640 in SFY 2023, $121,764 in SFY 2024 and $31,354 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 field office, at the Town of Vernon Social Services Department, or upon request from DSS (see below). When feasible and relevant, the versions of the SPA pages posted to that webpage include track changes indicating this SPA's proposed changes to the current version of the Medicaid State Plan.

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-U: Coverage and Payment Modifications for the Transition from the Coronavirus Disease 2019 (COVID-19) Federal Public Health Emergency (PHE)''.

Anyone may send DSS written comments about this SPA. **Written comments must be received by DSS at the above contact information no later than May 24, 2023**.

Department of Social Services

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 23-W: Chronic Disease Hospitals – Continuing Ventilation Bed Rate Add-On

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.

Proposed Changes to Medicaid State Plan

Effective July 1, 2023, this SPA will amend Attachment 4.19-A of the Medicaid State Plan to maintain the $500.00 per day add-on to the per diem rate for beds provided to patients on ventilators in free-standing licensed chronic disease hospitals, as defined in section 19a-550 of the Connecticut General Statutes. Under the current approved Medicaid State Plan and in accordance with 238 of Public Act No. 22-118, An Act Adjusting the State Budget for the Biennium Ending June 30, 2023, this add-on previously applied only during State Fiscal Year (SFY) 2023. DSS

anticipates that the funding to support this rate add-on will be maintained, so the purpose of this SPA is to remove the end-date for the add-on in the Medicaid State Plan and support continued access and quality for these services.

Estimated Fiscal Impact

DSS estimates that maintaining the add-on for chronic disease hospital ventilation beds will increase annual aggregate expenditures by approximately $11,000,000 in State Fiscal Year (SFY) 2024 and $11,000,000 in SFY 2025.

Obtaining SPA Language and Submitting Comments

This proposed SPA is posted on the DSS web site 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). When feasible and relevant, the versions of the SPA pages posted to that webpage include track changes indicating this SPA's proposed changes to the current version of the Medicaid State Plan.

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-W: Chronic Disease Hospitals – Continuing Ventilation Bed Rate Add-On''.

Anyone may send DSS written comments about the SPA. **Written comments must be received by DSS at the above contact information no later than June 8, 2023.**