NOTICE OF CONNECTICUT STATE AGENCIES

NOTICE OF INTENT TO APPLY FOR A STATE CERTIFICATE OF AFFORDABLE HOUSING COMPLETION

Notice is hereby given that the Town of New Canaan, Connecticut intends to file an Application for a Certificate of Affordable Housing Completion (moratorium on the applicability of Section 8-30g) with the Department of Housing of the State of Connecticut, pursuant to Section 8-30g(l)(4)(B) of the Connecticut General Statutes.

The proposed application, including all supporting documentation, is available for public inspection and comment in the Office of the Town Clerk, Town Hall, 77 Main Street (First Floor), New Canaan, Connecticut, from 8:00 a.m. to 3:00 p.m. Monday through Thursday and 8:00 a.m. to 1:00 p.m. on Fridays. Written comments may be submitted to Sarah Carey, Town Planner, at the Planning and Zoning Office in the lower level of Town Hall, 77 Main Street, within 20 days of the publication of this notice in the New Canaan Advertiser and the Connecticut Law Journal. The Town will hold a public hearing with respect to the proposed if a petition requesting a public hearing signed by at least twenty-five (25) residents of the Town is filed with the Town Clerk within the 20-day comment period. A copy of all written comments received and responses prepared by the Town will be included as part of the application to the Department of Housing.

Dionna Carlson
First Selectman
Town of New Canaan, CT

DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 24-A: January 2024 HIPAA Compliance and Reimbursement Updates

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

Changes to Medicaid State Plan

Effective on or after January 1, 2024, SPA 24-A will amend Attachments 3.1-A, 3.1-B, and 4.19-B of the Medicaid State Plan to make the updates to the coverage language and payment methodologies described below.

First, this SPA will incorporate various January 2024 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, medical equipment devices and supplies (MEDS), adult and children dental services, laboratory, audiology/speech & language pathology, ambulatory surgical centers, rehabilitation clinic, medical clinic, and behavioral

health clinic fee schedules. Codes that are being added are being priced using a comparable methodology to other codes in the same or similar category. DSS is making these changes to ensure the fee schedules remain compliant with the Health Insurance Portability and Accountability Act (HIPAA).

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 2024 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 2024 Medicare ASP Drug Pricing File and procedure codes that are described as ''unclassified'', as set forth in the existing approved payment methodology in the Medicaid State Plan, 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, this SPA will add periodontal Scaling & Root Planing (SRP) coverage and establish the rates for the Periodontal SRP services for children and adults as detailed below. The periodontal SRP codes will not be calculated into the Adult Benefit Maximum (ABM) established pursuant to section 17b-282c(a) of the Connecticut General Statutes because the codes will reimburse providers for services that are medically necessary as defined in section 17b-259b of the Connecticut General Statutes and therefore exempt from the ABM. The purpose of this change is to add coverage for periodontal SRP services, which are medically necessary dental services for Medicaid members, especially for those members who have comorbidity conditions that have been shown to be impacted negatively by periodontal disease.

Specifically, the following periodontal Current Dental Terminology (CDT) procedure codes are being added:

CDT Code	Description	Rates for Children and Adults
D0180	Comprehensive Periodontal Evaluation	$97.00
D4341	Periodontal SCRP Quadrant	$223.00
D4342	Periodontal SCRP; per 1 to 3 teeth	$129.00
D4355	Full Mouth Debridement	$153.00
D4910	Periodontal Maintenance	$138.00

Third, effective for dates of service on or after January 1, 2024, 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 code will be reimbursed separately from the encounter rate paid to federally qualified health centers (FQHCs). 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 code will be allowed to be billed and reimbursed as follows to FQHCs.

Procedure Codes	Description	Rates
G0512	Rural health clinic or federally qualified health center (RHC/FQHC) only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric COCM services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month.	$151.23

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

Fourth, pursuant to section 282 of Public Act 23-204, effective for the dates of service January 1, 2024, and forward, the reimbursement rates for adult (ages 19+) complex care skilled nursing services provided by home health agencies will be increased to equal the same rate for pediatric complex care skilled nursing services. The purpose of this change is to comply with this state law and to expand access to complex care skilled nursing services provided by home health agencies for adults.

Fifth, this SPA updates the rate for ParaGard, a long-acting reversible contraceptive (LARC) device 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 $1,085.00. The purpose of this change is to provide an updated rate that is sufficient to maintain access to this device.

Sixth, this SPA extends the following rate add-ons for pediatric inpatient psychiatric services currently approved in the Medicaid State Plan only through dates of service ending December 31, 2023. Specifically, this SPA extends the following rate add-ons, which are all currently in effect for another year, through December 31, 2024. Collectively, these rate add-ons are an interim voluntary value-based payment (VBP): (1) rate add-on to the applicable per diem rate for increasing bed capacity, utilization, and various reporting requirements that consists of a rate add-on to the applicable per diem rate, (2) an acuity-based add-on to the applicable per diem rate as authorized on a case-by-case basis, and (3) revision to the medically necessary discharge delay policy to provide reimbursement at the full per diem rate on a case-by-case basis. The purpose of these voluntary value-based payment opportunities is to help address the unmet need for pediatric inpatient psychiatric services and improve the quality of such services.

Lastly, this SPA implements the updates detailed below to the PCMH+ program, which is codified in the Medicaid State Plan as an Integrated Care Model within section 1905(a)(30) of the Social Security Act (Act), which is the Medicaid benefit category for ''any other medical care, and any other type of remedial care recognized under State law, specified by the [HHS] Secretary.'' PCMH+ involves shared savings payments and care coordination add-on payments for primary care case management (PCCM) services, as defined by section 1905(t) of the Act.

Under the language in the current Medicaid State Plan attachments noted above, in order to receive individual pool and challenge pool shared savings, each PCMH+ Participating Entity (PE) must improve on both the potentially preventable hospital admissions (PPA) and the potentially preventable hospital emergency department visits (PPV) compared to that PE's performance on each measure in the year prior to the performance year.

Each PE must continue to meet a quality gate for both the PPA and PPV measures. This SPA proposes to add flexibility to that requirement as detailed below. For each of the PPA and PPV measures, each PE must either: (1) be ranked within the top 30% of PEs for that measure in a performance year and/or (2) improve their score on that measure compared to the prior performance year. PEs will be eligible to qualify for shared savings payments for both the individual and challenge pools only if they meet at least one of these methods of meeting this updated quality gate for both PPA and PPV. All other requirements for potential eligibility for PCMH+ individual and challenge pools' shared savings payments continue to apply; the only change is to the quality gate for potential eligibility for such payments.

The purpose of the proposed change is to avoid penalizing PEs which have had consistent high performance on the PPA and/or PPV measures and to add necessary flexibility given the unpredictable nature of these measures given various unforeseeable impacts on such performance, such as new disease trends and other new reasons for higher than anticipated ED visits and/or hospital admissions unique to a performance year.

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

In aggregate, DSS anticipates that this SPA will increase annual aggregate expenditures by approximately $11,926,581 in State Fiscal Year (SFY) 2024 and $18,879,219 in SFY 2025.

DSS does not anticipate that the HIPAA compliant updates to the adult and children dental services, independent radiology, physician radiology, audiology/speech & language pathology services, rehabilitation clinics, and MEDS fee schedules will have any significant changes in annual aggregate expenditures.

The HIPAA update for the physician surgery fee schedule is estimated to have little to no financial impact, since utilization of the added codes is likely to shift utilization from existing codes on this fee schedule. However, to be conservative, DSS estimates that this change may increase annual aggregate expenditures by approximately $6,307 in SFY 2024 and $15,591 in SFY 2025.

The HIPAA update for the ambulatory surgical center fee schedule is estimated to increase annual aggregate expenditures by approximately $59,240 in SFY 2024, and $146,441 in SFY 2025.

The HIPAA compliant updates to the physician office and outpatient fee schedule is estimated to decrease annual aggregate expenditures by approximately $110,300 in SFY 2024 and $272,660 in SFY 2025. Note that DSS is not reducing any rates associated with this SPA; this decrease in expenditures is anticipated because the federal government end-dated a particular billing code.

DSS estimates that updating the physician-administered drugs according to the January 2024 Medicare ASP Drug Pricing File will increase annual aggregate expenditures by approximately $1,254,865 in SFY 2024 and $3,102,027 in SFY 2025.

HIPAA updates for laboratory services are estimated to increase annual aggregate expenditures by approximately $2,777 in SFY 2024 and $6,765 in SFY 2025

DSS estimates that reimbursing FQHCs separately for CoCM services will increase annual aggregate expenditures by approximately $193,574 SFY 2024 and $478,516 in SFY 2025.

DSS estimates that the HIPAA updates and addition of a vaccine to the medical clinic fee schedule will result in increasing annual aggregate expenditures by approximately $937 in SFY 2024 and $1,614 in SFY 2025.

The proposed addition of periodontal services available to adult and children HUSKY Health members is estimated to increase annual aggregate expenditures by approximately $1,387,791 in SFY 2024 and $3,430,620 in SFY 2025.

It is anticipated that the changes to complex nursing care rates for home health services will increase annual aggregate expenditures by approximately $1,080,673 in SFY 2024 and $2,671,424 in SFY 2025.

The proposed rate increase to ParaGard is estimated to increase annual aggregate expenditures by approximately $29,557 in SFY 2024 and $73,066 in SFY 2025.

The extension of the pediatric inpatient psychiatric services is estimated to increase annual aggregate expenditures by approximately $7,800,560 in SFY 2024 and $8,677,495 in SFY 2025.

DSS does not anticipate that the PCMH+ updates described above will result in any significant changes in annual aggregate expenditures. Adding the specified flexibility to the quality gate for a PCMH+ PE to potentially receive shared savings payments may affect the internal distribution of shared savings payments within the cohort of PEs but is unlikely to change the total amount of shared savings payments.

Obtaining SPA Language and Submitting Comments

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

To request a copy of the SPA from DSS or to send comments about the SPA, please email: **Public.Comment.DSS@ct.gov** or write to: Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105. Please reference ''SPA 24-A: January 2024 HIPAA Compliance and Reimbursement Updates''.

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 10, 2024**.