NOTICE OF CONNECTICUT STATE AGENCIES

DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 24-K: April 2024 HIPAA Compliance and Reimbursement Updates/ Updates to Person Centered Medical Homes/Human Breast Milk Donation/Addition of Select Laboratory Codes to the Family Planning Clinic Fee Schedule

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

Changes to Medicaid State Plan

Effective on or after April 1, 2024, SPA 24-K will amend Attachment 4.19-B of the Medicaid State Plan to incorporate various April 2024 federal Healthcare Common Procedural Coding System (HCPCS) updates (additions, deletions, and description changes) to the physician office and outpatient medical equipment devices and supplies (MEDS), 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).

Secondly, SPA 24-K will amend Attachment 4.19-B of the Medicaid State Plan to update the list of procedure codes eligible for the Person-Centered Medical Home (PCMH) Program add-on payment. Several procedure codes billed under the PCMH program will no longer be eligible for the PCMH add-on payment effective March 31, 2024. Identified procedure codes that were end-dated because they were either no longer a valid billing code according to the federally recognized Current Procedural Terminology (CPT) manual or based on the description of the procedure code, were determined to no longer meet the eligibility criteria for the PCMH add-on payment. Additionally, select procedure codes for evaluation/management visits and depression screenings will be eligible for the PCMH add-on payment. For a complete list of eligible procedure codes for the PCMH add-on payment, please visit https://www.huskyhealthct.org/providers/PCMH/pcmh_postings/PCMH_Codes_Enhanced_Reimbursemnt.pdf. DSS is making these changes to ensure that eligible procedure codes are billable and complies with program eligibility.

Third, SPA 24-K will amend Attachment 4.19-B of the Medicaid State Plan to incorporate the addition of select laboratory procedure codes to the family planning clinic fee schedule, which will allow family planning clinics to implement respiratory tests for COVID-19 and Influenza. This changes is being implemented to expand access to these services.

Lastly, as required by Section 17b-277c of the Connecticut General Statutes, SPA 24-K will amend Attachment 4.19-B of the Medicaid State Plan to provide coverage of outpatient human donor breast milk for infants, under one year old, who are active on Connecticut Medicaid and meet medical necessity as defined by the clinical

criteria established by DSS. Specifically, procedure code T2101 (human breast milk processing, storage, and distribution) will be added to the medical/surgical supplies fee schedule in order to allow coverage from enrolled milk banks accredited by the Human Milk Banking Association of North America (HMBANA). DSS is making this changes to comply with state law referenced above and enable coverage of outpatient human donor breast milk.

Fee schedules are published at: http://www.ctdssmap.com. Select ''Provider'', then select ''Provider Fee Schedule Download''; after accepting the terms and conditions, follow the prompts: Terms and Conditions, and go to the applicable fee schedule.

Fiscal Impact

The HIPAA 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 existing codes on the physician office & outpatient schedule. The deleted procedure codes had minimal paid amounts.

The HIPAA updates to the behavioral health clinic fee schedule are estimated to have little to no financial impact, since utilization of the added codes is likely to shift utilization from existing codes on the Behavioral Health Clinic schedule. The deleted procedure code, J0576-effective 1/1/24 through 3/31/24, had no paid amounts in SFY24 to date.

It is estimated that the HIPAA updates to Medical Equipment Devices and Supplies (MEDS) will increase annual aggregate expenditures by approximately $9,356 in SFY 2024, and $57,820 in SFY 2025.

It is estimated that the removal of select procedure codes and the addition of others to the eligibility for the PCMH Add-On payments will have a gross fiscal impact of $2,039 in SFY 2024, and $12,599 in SFY 2025.

It is anticipated that the addition of select laboratory codes to the family planning clinic fee schedule will increase Medicaid expenditures. The estimated gross increase in Medicaid program is $4,419 in SFY 2024, and $26,713 in SFY 2025.

DSS estimates that adding coverage of human donated breast milk is estimated to increase annual aggregate expenditures by approximately $59,400 in SFY 2024, and $364,420 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 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-K: April 2024 HIPAA Compliance and Reimbursement Updates/ Updates to Person Centered Medical Homes/Human Breast Milk Donation/Addition of Select Laboratory Codes to the Family Planning Clinic Fee Schedule''.

Anyone may send DSS written comments about this SPA. Written comments must be received by DSS at the above contact information no later than **April 10, 2024**.

DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 24-G Changes to Pharmacy Reimbursement for Alcohol Prep Pads and Blood Glucose Test Strips

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 April 1, 2024, this SPA 24 will amend Attachment 4.19-B of the Medicaid State Plan to make updates to the payment methodologies described below:

When provided by a pharmacy, (a) the rate for blood glucose testing strips will be WAC (Wholesale Acquisition Cost) with no dispensing fee and (b) alcohol prep pads will be capped at a maximum reimbursement amount of $6.00 per 100 prep pads with no dispensing fee.

DSS is making both of these changes in order to achieve reimbursement parity between the same items when provided through the medical equipment, devices and supplies (MEDS) benefit and the pharmacy benefit. Access to both products will still be available through either the Pharmacy Prescription (POS) or MEDS benefit.

Fiscal Impact

DSS estimates that this SPA will decrease annual aggregate expenditures by approximately fiscal impact of $(403,315) in State Fiscal Year (SFY) 2024, $(2,492,485) in SFY 2025 and $(2,567,260) in SFY 2026.

Compliance with Federal Access Regulations

In accordance with federal regulations at 42 C.F.R. §§ 447.203 and 447.204, DSS is required to ensure that there is sufficient access to Medicaid services, including services where payment rates are proposed to be reduced. Those federal regulations also require DSS to have ongoing mechanisms for Medicaid members, providers, other stakeholders, and the public to provide DSS with feedback about access. In addition to other available procedures, anyone may send DSS comments about the potential impact of this SPA on access to these supplies for which rates are being reduced or payment is being restructured in a manner that could affect access, as part of the public comment process for this SPA. Contact information and the deadline for submitting public comments are listed below. In this SPA, DSS does not anticipate that this SPA will have any negative impact on access because these changes will simply ensure that the maximum reimbursement for these items is the same when provided through both the MEDS and pharmacy benefits.

Obtaining SPA Language and Submitting Comments

This 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 or the Town of Vernon Social Services Department, or upon request from DSS (see below).

To request a copy of the SPA from DSS or to send comments about the SPA, please email: Public.Comment.DSS@ct.gov or write to: Medical Policy Unit, Department of Social Services, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105. Please reference ''SPA 24-G**: Changes to Pharmacy reimbursement for Alcohol Prep Pads and Blood Glucose Test Strips''**

Anyone may send DSS written comments about the SPA. Written comments must be received by DSS at the above contact information no later than **April 25, 2024**.

DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 24-0008: Interim Payments to Providers Affected by the Change Healthcare Cybersecurity Incident

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 retroactive to February 22, 2024 and through dates of service no later than June 30, 2024, this SPA will amend Section 7 of the Medicaid State Plan by adding a new Section 7.4-C to make interim payments as described below. This SPA does not change any underlying covered services or payment methodology, which continue to be governed by the applicable provisions of the Medicaid State Plan in effect at the time services were provided.

This SPA is being submitted in accordance with the CMS Center for Medicaid and Children's Health Insurance Program (CHIP) (CMCS) Informational Bulletin (CIB) dated March 15, 2024 and posted to the CMS website at this link: https://www.medicaid.gov/sites/default/files/2024-03/cib031524.pdf. The purpose of this SPA is to enable the state to make interim payments to providers whose ability to submit Medicaid claims were disrupted by the recent cybersecurity incident at Change Healthcare, a unit of UnitedHealth Group. Pursuant to the CIB, the state will provide interim payments to affected providers to maintain continuity of care to members without interruption. This SPA does not change any covered services or payment methodology, which continue to be governed by the applicable provisions of the Medicaid State Plan in effect at the time services were provided.

Effective retroactively to February 22, 2024, and effective for affected services provided on or before June 30, 2024, Medicaid providers that can demonstrate to the state with proper documentation that their ability to process and submit Medicaid claims was disrupted by the Change Healthcare cybersecurity incident (the incident) can request to receive interim payments for covered Medicaid services in accordance with this section. These payments will be in amounts representative of each applicable claims cycle, as set forth below under ''Interim Payment'' for services that were not otherwise paid as a result of the incident.

Eligible Provider Types

Eligible provider types include, but are not limited to the providers providing services and billing under each of the following Medicaid State Plan benefit categories within section 1905(a) of the Social Security Act unless specified otherwise below, each of which is defined in more detail in the applicable section of Attachments 4.19-A, 4.19-B, or 4.19-D:

- Inpatient Hospital (section 1905(a)(1)),
- Outpatient Hospital (section 1905(a)(2)(A)),
- Federally Qualified Health Centers (section 1905(a)(2)(C)),
- Home Health (section 1905(a)(7)), including all applicable subcategories of 42 C.F.R. § 440.70 (i.e., nursing services, home health aide services, therapy services, and medical equipment, devices and supplies),
- Clinic Services (section 1905(a)(9)),
- Rehabilitation Services (section 1905(a)(13)(C)),
- Early and Periodic Screening Diagnostic and Treatment (EPSDT) (section 1905(a)(4)(B), specifically the School-Based Child Health (SBCH) benefit,
- Outpatient Prescription Drugs (Pharmacy) (section 1905(a)(12)),
- Physician Services (section 1905(a)(5)),
- Other Licensed Practitioner (section 1905(a)(6)), including all categories covered in Attachment 3.1-A of the Medicaid state plan (e.g., nurse practitioner, behavioral health clinician, podiatrist, naturopath, psychologist, acupuncturist, etc.),
- Dentist (section 1905(a)(10)),
- Hospice (section 1905(a)(18)),
- Intermediate Care Facility for Individuals with Intellectual Disabilities (section 1905(a)(15)), and
- Any other benefit category covered by the state under the Medicaid State Plan or section 1915(c) waiver and for which the provider demonstrates to the state that it was affected by the incident as detailed above.

Interim Payment

Medicaid providers are currently reimbursed via biweekly claim cycles with one three-week claim cycle occurring each quarter. Interim payments will be calculated in accordance with the methodology outlined below.

1. For biweekly claim cycles the payment amounts will be estimated for each impacted provider using the average biweekly claim cycle payment amount reimbursed between July 1, 2023, through February 29, 2024.
2. For three-week claim cycles the payment amounts will be estimated for each impacted provider using the average three-week claim cycle payment amount reimbursed between July 1, 2023, through February 29, 2024.
3. For each claims cycle during the effective dates of this section for which the provider is requesting an interim payment, the interim payments will be calculated as: (a) the estimated average biweekly or three-week claim cycle payment amounts, as applicable to the claims cycle minus (b) the amount that was actually paid in the impacted claim cycle.

Interim payments will be made for services provided through June 30, 2024, for as long as the provider is impacted by the incident.

Reconciliation

The payments authorized under this section are not advanced payments or prepayments prior to services furnished by providers. These interim payments will be

reconciled to the final payment amount the provider was eligible to receive under the Medicaid state plan for its applicable provider type reimbursement during the timeframe for which it was receiving interim payments under this provision based on the actual covered services performed by the provider for Medicaid members. The reconciliation will be completed no later than September 30, 2024, except that, on a case-by-case basis, a provider may request an extension of time from the state and subject to the state's approval but no later than December 31, 2024 to complete the reconciliation due to extenuating circumstances documented by the provider and provided further that the provider demonstrates that it is taking reasonable efforts to expedite the reconciliation.

If the reconciliation results in discovery of an overpayment to the provider, the state will attempt to recoup the overpayment amounts within ninety (90) days and will return the federal share within the timeframe specified in 42 C.F.R. §§ 433.316 and 433.320 regardless of whether the state actually recoups the overpayment amount from the provider, unless an exception applies under 42 C.F.R. part 433, subpart F.

If the reconciliation results in an underpayment to the provider, the state will make an additional payment to the provider in the amount of the underpayment within 90 days.

Assurances

The state will follow all applicable program integrity requirements relating to interim payments to providers and the associated reconciliation process. The state will ensure that all providers receiving payments under this interim methodology will continue to furnish applicable services to Medicaid beneficiaries during the interim payment period and that access to such services is not limited.

As described above, the purpose of this SPA is to provide financial support to Medicaid providers so that they can continue to provide essential care for Medicaid enrollees.

Fiscal Impact

DSS anticipates that this SPA will not have a significant impact on annual aggregate expenditures in State Fiscal Year (SFY) 2024 and SFY 2025 because this SPA authorizes interim payments intended to make providers whole relative to the level of funding currently budgeted and those payments will then be reconciled to actual services provided.

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).

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Anyone may send DSS written comments about this SPA. Written comments must be received by DSS at the above contact information no later than **April 25, 2024**.