

**DEPARTMENT OF SOCIAL SERVICES
NOTICE OF PROPOSED CHANGES TO THE STATE MEDICAID PLAN**

SPECIAL NOTICE – February 28, 2013

On December 31, 2012, the Department issued public notice in the newspapers of its intent to submit a Medicaid State Plan Amendment (SPA) concerning FQHC PCMH Reimbursement; ASO Transitional payments and General Acute Care Children's Hospital Supplemental Payments under SPA # 13-008 and 13-009. The Department has combined these two SPAs and placed them under SPA #13-008.

The Department has extended the time frame for the submission of comments to March 14, 2013.

Please mail or e-mail your comments to: Ginny Mahoney, Department of Social Services, Medical Policy Unit, 25 Sigourney Street, 11th Floor, Hartford, CT 06106-5033, Telephone: (860) 424-5145, Fax: (860) 424-5799, Email: ginny.mahoney@ct.gov. Please reference SPA TN # 13-008 FQHC PCMH Reimbursement and Hospital Payments.

Please find below the original public notice followed by the State Plan language concerning Pharmacy Services.

FQHC PCMH REIMBURSEMENT (SPA 13-008)

Effective on or after January 1, 2013, the Department will amend the Medicaid state plan to eliminate all payments to Federally Qualified Health Centers (FQHCs) under the PCMH program, including payments to FQHCs participating as both Glide Path and PCMH providers. The PCMH-related payments proposed to be eliminated by this SPA include: (1) rate add-ons to the encounter rate for each Federally Qualified Health Center participating as a Glide Path or PCMH provider, (2) supplemental payments for quality performance incentives for FQHCs participating as PCMH providers, and (3) supplemental payments for quality performance improvement for FQHCs participating as PCMH providers. The final fiscal impact for SFY 2013 and SFY 2014 has not yet been determined, although a savings is projected.

The Department will implement this change either under a new SPA, or alternatively, through a revision to SPA 12-005, which is currently pending with CMS.

ASO TRANSITIONAL PAYMENTS - OUTPATIENT HOSPITAL SERVICES (SPA 13- 009)

General Acute Care and Private Psychiatric Hospital Supplemental Payments

Effective on or after January 1, 2013, the Department will reduce the supplement

payments that were developed during the Department's conversion from a managed care to a fee-for-service structure on January 1, 2012, including certain amounts carried forward from SFY 2012. Section 4 of HB 7001 permits the Department to consider utilization in setting hospital outpatient rates. The Department will reduce the proposed outpatient supplemental payments by \$22.8 million, generating a gross savings of that amount. The reason for the change is that outpatient hospital utilization rose significantly during the transition to the ASO, resulting in increased outpatient hospital revenues. This supplemental payment reduction reflects that increase and will mitigate the financial effect of the transition for the Department.

The final fiscal impact for SFY 2013 and SFY 2014 has not yet been determined, although a savings is projected. The Department will implement this change either under a new SPA, or alternatively, through a revision to SPA 12-005, which is currently pending with CMS.

General Acute Care Children's Hospital Supplemental Payments

Effective on or after January 1, 2013, the Department will also reduce supplemental payments for general acute care children's hospitals, by \$4.2 million, including certain amounts carried forward from SFY 2012, generating a gross savings of that amount. This change is also necessary to mitigate the increases in utilization and expenditures that developed under the new ASO payment structure.

The Department will implement this change either under a new SPA, or alternatively, through a revision to SPA 12-005, which is currently pending with CMS. The final fiscal impact for SFY 2013 and SFY 2014 has not yet been determined, although a savings is projected.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –
OTHER TYPES OF CARE

(2)

(a) **Outpatient hospital services** – The agency’s fixed fees were set as of January 1, 2012 and are effective for services on or after that date. All fixed fees are published on the Department’s website at www.ctdssmap.com. Rates that are based on hospital service specific ratio of cost to charges are included on each provider’s rate schedule. The rate schedule is sent to the hospital and is revised annually (July 1) based on the most recently filed cost report. Except as otherwise noted in the plan, state developed fee schedules and rate methods are the same for both governmental and private providers.

Effective January 1, 2012, evaluation rates for Child and Adolescent Rapid Emergency Stabilization Services (CARES) provided in a designated general hospital unit with an approved Certificate of Need that specifically provides for the operation of a CARES unit for such services shall be \$450.00 per encounter. This is a comprehensive medical and psychiatric evaluation, including an evaluation by a psychiatrist, for complex emergency department presentations with a special emphasis on clinically appropriate disposition planning.

Person Centered Medical Home (PCMH) practices are individual outpatient hospital clinic sites that have met National Committee for Quality Assurance (NCQA) Level 2 or Level 3 medical home recognition. PCMH practices must comply with all NCQA PCMH requirements and all additional written department requirements, including participation in various primary care initiatives operated by the State.

The department offers a PCMH Glide Path program, which pays enhanced rates to outpatient hospital clinics that are providing some of the additional Medicaid services required for NCQA PCMH recognition. In order to qualify for Glide Path, a clinic must demonstrate that it has begun providing a more advanced standard of primary care and has committed to achieving NCQA PCMH recognition in a set period of time. Glide Path practices must also comply with all additional written department requirements, including participation in various primary care initiatives operated by the State.

Beginning January 1, 2012, outpatient hospital clinics participating in PCMH and Glide Path may be eligible for an add-on to the per visit medical rate for visits that included one or more procedures corresponding to the procedure codes on the physician fee schedule listed below. Outpatient hospital clinics participating in PCMH may also be eligible for retrospective annualized supplemental payments for performance incentives and performance improvement.

TN # 13-008
Supersedes
TN # 12-005

Approval Date _____

Effective Date 01-01-2013

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1. Glide Path and PCMH Rate Add-On to the Outpatient Hospital Clinic Medical Visit Rate

The rate add-on is paid in addition to the outpatient hospital medical visit rate for visits that include one or more procedures corresponding to the following procedure codes on the physician fee schedule: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99339, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99354, 99355, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99406, 99407, 99408, 99409, 99411, 99412, 99374, 99377, 99379, 99380, 96110, 99050, 99051, 99053, D0145, D1206, and 99420. These codes were selected to pay providers for providing a more advanced level of primary care and to encourage more providers to provide primary care to beneficiaries, which will help expand access to primary care services. For a procedure that is included in a qualifying outpatient hospital clinic medical visit that was provided to a beneficiary outside of the outpatient hospital clinic in a nursing facility, rest home, or the beneficiary's home, the applicable rate add-on will be paid if the beneficiary is attributed to the outpatient hospital clinic. The rate add-on is paid at the same time as the underlying claim and is scaled based on the stages of NCQA PCMH recognition:

- i. For Glide Path clinics, the total payment for each visit that included one or more procedures corresponding to the procedure codes listed above, including the rate add-on, is 109% of the medical visit rate.
- ii. For NCQA PCMH Level 2, the total payment for each visit that included one or more procedures corresponding to the procedure codes listed above, is 114% of the medical visit rate.
- iii. For NCQA PCMH Level 3, the total payment for each visit that included one or more procedures corresponding to the procedure codes listed above, is 116% of the medical visit rate.

2. PCMH Supplemental Payments for Outpatient Hospital Clinic Performance

For PCMH practices only, the two types of supplemental payments detailed below will be paid to outpatient hospital clinic PCMHs on a retrospective annualized basis based upon an attribution methodology, where recipients will be attributed to outpatient hospital clinic PCMHs based on their claims history, in accordance with the department's current written attribution methodology. The attribution methodology assigns recipients to primary care practitioners based on claims volume analyzed retrospectively every three calendar months. If a recipient receives care from multiple providers during a given period, the recipient is

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assigned to the practice that provided the plurality of care and if there is no single largest source of care, to the most recent source of care. Recipients may affirmatively select a PCMH practice as their primary care provider and will be attributed to that practice unless the recipient later receives more care from another practice. Payments will be issued to eligible outpatient hospital clinic PCMHs retrospectively in a lump sum on an annualized basis during the quarter ending June 30th for services provided in the previous calendar year (the “measurement year”).

- a. **Supplemental Payment for Performance Incentives:** Outpatient hospital clinics that meet all requirements for this supplemental payment will receive a payment totaling a maximum of \$0.97 for each member’s enrollment month attributed to the clinic. Payments will be issued retrospectively in a lump sum on an annualized basis during the quarter ending June 30th for services provided in the previous calendar year. The payment amount will be based on the clinic’s performance compared with all other PCMH practices during the measurement year using the quality performance measures described in subsection (2)(d) below. PCMH practices are eligible for this payment only if they participate as a PCMH for the entire measurement year. The tiers of performance are as follows:

Performance Percentile	Level of Supplemental Payment
Under 25th percentile	No payment
25th–50th percentile	25% of possible payment
51st–75th percentile	50% of possible payment
76th–90th percentile	75% of possible payment
91st–100th percentile	100% of possible payment

- b. **Supplemental Payment for Performance Improvement:** Outpatient hospital clinic PCMHs that meet all requirements for this supplemental payment will receive a payment totaling a maximum of \$0.81 for each member’s enrollment month attributed to the clinic. Payments will be issued retrospectively in a lump sum on an annualized basis during the quarter ending June 30th for services provided in the previous calendar year. PCMH practices are eligible for this payment only if they have participated as a PCMH for at least two full calendar years. The payment amount will be based on the practice’s performance using the quality performance measures described in subsection (2)(d) below.

The Department will make tiered payments based on each clinic’s degree of improvement compared with the previous year. Performance targets and tiers will be set collectively and for each quality performance measure described in subsection (2)(d) below based on the clinical or social significance of each measure and the practice’s ability and need to

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improve in each measure. The tiers will be adjusted each year to account for variation in past performance. Clinics performing at a very high level at both baseline and measurement years will be eligible for this supplemental payment even without any improvement in a given measurement year.

(b) Rural health clinic services – not provided.

(c) Federally Qualified Health Centers (FQHC) rates are set according to the Regulations of Connecticut State Agencies, governing community health centers (Attached Page 1(b) Addendum). The rate setting methodology conforms to the prospective payment system under Medicare, Medicaid and SCHIP Benefits Improvement and Protections Act (BIPA) of 2000.

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- (d) Quality Performance Measures for PCMH Program. The department's quality performance measures for the PCMH program were established as of January 1, 2012 and are effective for measurement of provider services and care outcomes on or after that date. The quality performance measures can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. The quality measures are used to measure PCMH practices' performance and their eligibility for certain payments that are described in the relevant section of the plan as being made or determined using these quality measures. These quality measures are based on improving quality, access, and care outcomes.