

DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

Reimbursement Update – Autism Spectrum Disorder Services (SPA 16-0029)

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.

Changes to Medicaid State Plan

Effective on or after September 1, 2016, SPA 16-0029 will amend Attachment 4.19-B of the Medicaid State Plan in order to update the reimbursement methodology for autism spectrum disorder (ASD) services to make the following changes. Specifically, this SPA will add billing codes that must be used when a technician or Board Certified Assistant Behavior Analyst (BCaBA) provides ASD treatment services under the supervision of a qualified Board Certified Behavior Analyst (BCBA) or licensed practitioner. The new codes are CPT code 0364T for the initial 30 minutes and CPT code 0365T for all subsequent 30 minute units, which will each be reimbursed at \$22.50 per 30-minute unit (equivalent to \$45 per hour). Under the previous fee schedule, all ASD treatment services were reimbursed in fifteen-minute units equivalent to \$48 per hour. A higher rate (as modified by SPA 16-0004, effective July 1, 2016) is available when a qualified BCBA or licensed practitioner directly provides ASD treatment services. As part of SPA 16-0004, effective July 1, 2016, the rate for services provided directly by BCBA's was increased and additional services will now be reimbursed, including direct observation and direction, group ASD treatment services, and development of a program book. The changes proposed by this SPA are necessary to reimburse more efficiently for ASD treatment services performed by BCaBA's and technicians.

Fiscal Impact

DSS estimates that this SPA will reduce annual aggregate expenditures by approximately \$514,000 in State Fiscal Year 2017 and \$634,000 in State Fiscal Year 2018. However, when considered together with the rate increases and additional reimbursable services added by SPA 16-0004 effective July 1, 2016, the overall expenditures for all of these services are expected to increase.

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 or restructured in a manner that might affect access. 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 autism spectrum disorder treatment services as part of the public

comment process for this SPA. Contact information and the deadline for submitting public comments are listed below.

Obtaining SPA Language and Submitting Comments

The proposed SPA is posted on the DSS website at this link: <http://www.ct.gov/dss>. Go to “Publications” and then “Updates.” The proposed SPA may also be obtained at any DSS field office and upon request from DSS.

To request a copy of the SPA or to send comments about the SPA, please email: ginny.mahoney@ct.gov or write to: Ginny Mahoney, Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105 (Phone: 860-424-5145, Fax: 860-424-5799). Please reference: SPA 16-0029: Reimbursement Update – Autism Spectrum Disorder Services.

Anyone may send DSS written comments about this SPA, including comments about access to services affected by this SPA. Written comments must be received at the above contact information no later than August 25, 2016.

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

(2) (a) Outpatient hospital services –

Effective for dates of service on or after September 1, 2016, the Connecticut Medical Assistance Program (CMAP) Outpatient Prospective Payment System (OPPS) reimbursement methodology described in this section applies to all outpatient hospital services except for publicly operated outpatient hospital psychiatric services as described further below in the outpatient hospital section of Attachment 4.19-B. Within CMAP OPPS, the Ambulatory Payment Classification (APC) reimbursement methodology shall apply to all outpatient services except as otherwise provided in CMAP Addendum B, as explained below. Except as otherwise noted in the plan, state developed fee schedules and rate methods are the same for both governmental and private providers.

Definitions

1. “APC” or “Ambulatory Payment Classification” means the classification of clinically similar outpatient hospital services that can be expected to consume similar amounts of hospital resources and serves as one of the methods of payment under CMAP’s OPPS.
2. “APC conversion factor” means a set dollar amount determined by the department that is used as the basis for calculating the payment for outpatient hospital services based on the APC payment methodology.
3. “APC grouper” means the program that assigns each service on an outpatient claim an APC if appropriate, as well as assigning a status indicator that specifies if and how the provider will be reimbursed for a service.
4. “APC relative weight” means the relative value assigned to each APC and is the same as Medicare’s weight.
5. “CMAP Addendum B” means the Connecticut Medical Assistance Program’s document that lists HCPCS codes and describes payment information regarding outpatient hospital services.
6. “CMAP’s Outpatient Prospective Payment System” or “OPPS” means the department’s outpatient prospective payment system for outpatient hospital services as described in this section, which is the department’s prospectively determined payment system for outpatient hospital services that are reimbursed using APCs, the applicable fee schedule or such other prospective payment methodology as established by the department as described in CMAP Addendum B.
7. “Wage index” means the index published by CMS pursuant to 42 USC 1395ww(d)(3)(E) but not including any adjustments for geographic reclassification of hospitals to other labor market areas.

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Overall Payment Methodology

1. Outpatient hospital services are provided pursuant to 42 CFR 440.20.
2. No inflation, inflationary factor, or any other automatic increase is included in any reimbursement for outpatient hospital services. Reimbursement is solely based upon the methodology described below.
3. Reimbursement for outpatient hospital services and other services prior to inpatient hospital admission.
 - a. Except as provided in subdivision b. of this subsection, reimbursement for inpatient hospital services includes payment for all outpatient hospital services provided by the hospital or another hospital that is an affiliate of the hospital at any location, including the hospital's main campus and any satellite location, on the date of admission and the two days prior to the date of admission, which shall not be separately reimbursed by the department and shall be billed as part of the inpatient hospital stay.
 - b. The department pays a hospital or an affiliate of the hospital separately for the following services provided on the date of admission but before the actual admission and the two days prior to the date of admission: Any service clinically unrelated to the admission, maintenance renal dialysis, physical therapy, occupational therapy, speech and language pathology services, audiology services, routine psychotherapy, electroconvulsive therapy (except if the electroconvulsive therapy causes the admission), psychological testing, neuropsychological testing, intermediate care programs and any other category of service specifically designated on the outpatient hospital fee schedule referenced below.
4. The Department shall pay hospitals for providing outpatient hospital services using CMAP OPPS. As determined and designated by the department, services are paid using one or more of the following methodologies and in accordance with the department's fee schedules and payment rules as defined in CMAP Addendum B, which has been updated as of September 1, 2016 and is posted to www.ctdssmap.com.
 - a. APC payment based on Medicare's system as modified for CMAP, as detailed below,
 - b. A fee on the department's fee schedule for outpatient hospitals, which has been updated as of September 1, 2016 and is posted to www.ctdssmap.com,
 - c. A fee on one of the department's fee schedules other than the outpatient hospital fee schedule. For each service that is paid using a fee schedule, CMAP Addendum B specifies the applicable fee schedule, each of which is updated as of the effective

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- date listed in the applicable section of Attachment 4.19-B and is also posted to www.ctdssmap.com, or
- d. Other prospective payment as included on CMAP Addendum B.
5. The department shall pay a hospital at the lowest of:
- a. The applicable APC payment, fee schedule payment, or other prospective payment,
 - b. The hospital's charges,
 - c. Applicable reimbursement from Medicare, except for any services designated by the department as being reimbursed at rates higher than Medicare, or
 - d. For laboratory services provided by a hospital, the lowest price, including all third party negotiated discounts, charged or accepted for the same or substantially similar goods or services by the hospital or affiliate of the hospital from any person or entity, except that a billing provider may occasionally charge or accept a lesser amount if the billing provider shows that an individual who received services from such provider had a financial hardship, without affecting the amount paid by the department for the same or substantially similar goods or services.

Payment Rate and Limitations for Hospitals Reimbursed Using APCs

CMAP's APC system is based on Medicare's Addendum B (OPPS Payment by HCPCS Code as modified as reflected in CMAP Addendum B), Addendum A (list of APCs) and Addendum D1 (list of payment status indicators) and uses Medicare's APC grouper software. Effective July 1, 2016, APC IOCE Version 17.1 will be used. When Medicare issues subsequent APC IOCE versions, CMAP's APC system will adopt such version with the same dates of service effective date as Medicare. . . In order to implement each such new version, the department will update Addendum B in accordance with such version and in conformance with the existing methodology and policy as reflected on the current version of Addendum B.

CMAP Addendum B also includes a column entitled "Payment Type" that indicates whether an item is reimbursable based on the APC methodology, the applicable fee schedule or other prospective payment methodology.

- 1. Effective for services provided on or after July 1, 2016, for applicable services as specified on CMAP Addendum B, the department pays for outpatient hospital services on a fully prospective per service basis using an APC payment methodology in accordance with this section.
- 2. The department established a statewide conversion factor of \$82.25 for general acute care children's hospitals and \$71.76 for all other hospitals.
- 3. The conversion factor is adjusted for the hospital's geographic wage index based on the original Medicare assignment. Medicare reclassifications will not be recognized. The wage index is applied to 60% of the conversion factor.

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13. c. Preventive Services

Services to Treat Autism Spectrum Disorders Pursuant to EPSDT

Fees for services to treat autism spectrum disorders pursuant to EPSDT were set as of September 1, 2016 and are effective for services provided on or after that date. The fee schedules can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page, go to “Provider,” then to “Provider Fee Schedule Download” and select the fee schedule applicable to the qualified provider. Fees are the same for governmental and private providers.

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(5) Physician's services – Fixed fee schedule not to exceed the Medicare physician fee schedule. The current fee schedule was set as of September 1, 2016 and is effective for services provided on or after that date. The fee schedule for physicians can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download." All governmental and private providers are reimbursed according to the same fee schedule.

Person-Centered Medical Home (PCMH) practices are individual sites of independent physician groups, solo physician practices, nurse practitioner groups, and individual nurse practitioners 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 practices that are providing some of the additional Medicaid services required for NCQA PCMH recognition. In order to qualify for Glide Path, a practice 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, PCMH and Glide Path practices may be eligible for a rate add-on to the procedure codes on the physician fee schedule identified below. PCMH practices may also be eligible for retrospective annualized supplemental payments for performance incentives and performance improvement. Independent physician-led Glide Path practices with five or fewer full-time equivalent practitioners across all practice locations may also be eligible for a supplemental payment at each Glide Path phase.

(a) Glide Path and PCMH Rate Add-On: The department will pay a rate add-on for the following procedures in addition to the amounts listed for each procedure code 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,

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- (6) Medical care or any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. Fixed fee methodologies are summarized below.
- (a) Podiatrists – Podiatrists – 90% of physician fees as noted in (5) above. The current fee schedule was set as of January 1, 2016 and is effective for services provided on or after that date. The fee schedule can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page, go to “Provider,” then to “Provider Fee Schedule Download.” All governmental and private providers are reimbursed according to the same fee schedule.
 - (c) Optometrists – 90% of physician fees as noted in (5) above. The current fee schedule was set as of January 1, 2016 and is effective for services provided on or after that date. The fee schedule can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page, go to “Provider,” then to “Provider Fee Schedule Download.” All governmental and private providers are reimbursed according to the same fee schedule.
 - (c) Chiropractors – 100% of physician fees as noted in (5) above. The current fee schedule was set as of January 1, 2012 and is effective for services provided on or after that date. The fee schedule for chiropractors can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page, go to “Provider,” then to “Provider Fee Schedule Download.” All governmental and private providers are reimbursed according to the same fee schedule. Chiropractor services are paid only as EPSDT Special Services required by Section 1905(r)(5) of the Social Security Act.
 - (d) Other licensed practitioners –
 - (i) Psychologists – The current fee schedule was set as of September 1, 2016 and is effective for services provided on or after that date. The fee schedule for psychologists can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page, go to “Provider,” then to “Provider Fee Schedule Download.” All governmental and private providers are reimbursed according to the same fee schedule.

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(ii) Naturopaths – The current fee schedule was set as of January 1, 2012 and is effective for services provided on or after that date. The fee schedule for naturopaths can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page, go to “Provider,” then to “Provider Fee Schedule Download.” Rates are the same for private and governmental providers and are published at www.ctdssmap.com.

(iii) Nurse practitioners – 90% of physician fees as referenced in (5) above, except for physician-administered drugs and supplies and services rendered by certified registered nurse anesthetists, which are reimbursed at 100% of the physician fees. The current fee schedule was set as of September 1, 2016 and is effective for services provided on or after that date. The fee schedule for physicians can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page, go to “Provider,” then to “Provider Fee Schedule Download.” Rates are the same for private and governmental providers and are published at www.ctdssmap.com.

Nurse practitioner groups and individual nurse practitioners are eligible to participate in the Person-Centered Medical Home (PCMH) initiative detailed in (5) above under Physician’s Services. Nurse practitioner services within PCMH practices run by nurse practitioners are authorized by Section 1905(a)(6) (services by other licensed practitioners). Nurse practitioners working in a physician group or a solo physician practice are eligible to participate in the PCMH initiative as part of the physician group or solo physician practice under the Physician’s Services section of the State Plan.

(iv) Dental Hygienists - 90% of the department’s fees for dentists. The fee schedule for dentists can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page, go to “Provider,” then to “Provider Fee Schedule Download.” The agency’s rates were set as of April 1, 2008 and are effective for services on or after that date. Rates are the same for private and governmental providers and are published at www.ctdssmap.com.

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(v) Licensed behavioral health practitioners to include licensed clinical social workers, licensed marital and family therapists, licensed professional counselors, and licensed alcohol and drug counselors – not to exceed 75% of the Medicare physician fee schedule. The fee schedule for licensed behavioral health practitioners can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page go to “Provider,” then to “Provider Fee Schedule Download.” The agency’s rates were set as of September 1, 2016 and are effective for services on or after that date. Rates are the same for private and governmental providers and are published at www.ctdssmap.com.

(vi) Physician assistants – 90% of the department’s fees for physicians, except for physician-administered drugs and supplies, which are reimbursed at 100% of the physician fees. The fee schedule for physicians can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page go to “Provider,” then to “Provider Fee Schedule Download.” The agency’s rates were set as of September 1, 2016 and are effective for services on or after that date. Rates are the same for private and governmental providers and are published at www.ctdssmap.com.

Physician assistants working in a physician group or a solo physician practice are eligible to participate in the Person-Centered Medical Home (PCMH) initiative detailed in (5) above under Physician’s Services as part of the physician group or solo physician practice under the Physician’s Services section of the State Plan in Section (5) above.

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- (17) Nurse-mid wife services - are paid off of the physician fee schedule at 90% of physician fees, except for physician-administered drugs and supplies, which are reimbursed at 100% of the physician fees.

The agency's physician fee schedule was set as of September 1, 2016 and is effective for services provided on or after that date, except that fees may be deleted or added and priced in order to remain compliant with HIPAA. The physician fee schedule can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page go to "Provider Services" then to "Fee Schedule Download". All governmental and private providers are reimbursed according to the same fee schedule.

- (18) The Medicaid Hospice rates are set prospectively by CMS based on the methodology used in setting Medicare Hospice rates, which are adjusted to disregard the cost offsets attributable to Medicare coinsurance amounts. Hospice payment rates are also adjusted for regional differences in wages, using indices published in the Federal Register and daily Medicaid hospice payment rates announced through CMS's memorandum titled "Annual Change in Medicaid Hospice Payment Rates—ACTION". The hospice fee schedule can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page, go to "Provider" then to "Provider Fee Schedule Download". All governmental and private providers are reimbursed according to the same fee schedule. For clients living in a nursing facility, the per diem nursing facility rate will equal 95% of the rate for that nursing home under the Medicaid program.

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- (21) Pediatric and family nurse practitioners – are paid off of the physician fee schedule at 90% of physician fees, except for physician-administered drugs and supplies, which are reimbursed at 100% of the physician fees. The agency’s physician fee schedule was set as of September 1, 2016 and is effective for services provided on or after that date. The physician fee schedule can be accessed and downloaded by going to the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page, go to “Provider” then to “Provider Fee Schedule Download”. All governmental and private providers are reimbursed according to the same fee schedule.

Pediatric and family nurse practitioner groups and individual pediatric and family nurse practitioners are eligible to participate in the Person-Centered Medical Home (PCMH) initiative detailed in (5) above under Physician’s Services. Pediatric and family nurse practitioner services within PCMH practices run by pediatric and family nurse practitioners are authorized by Section 1905(a)(21) (services by certified pediatric and family nurse practitioners). Pediatric and family nurse practitioners working in a physician group or a solo physician practice are eligible to participate in the PCMH initiative as part of the physician group or solo physician practice under the Physician’s Services section of the State Plan.

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