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State/Territory Name: Connecticut

State Plan Amendment (SPA) #: 16-0015

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form/Summary Form
- 3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203



Division of Medicaid and Children's Health Operations/ Boston Regional Office

October 17, 2018

Roderick Bremby, Commissioner
Department of Social Services
55 Farmington Avenue
Hartford, CT 06105

Dear Commissioner Bremby:

We are pleased to enclose via email a copy of approved Connecticut State Plan Amendment (SPA) No. 16-0015, submitted to my office on March 31, 2016 and approved on October 15, 2018.

This SPA amends Attachments 3.1-A, 3.1-B, and 4.19-B of the Medicaid State Plan to update the description of coverage and reimbursement of Federally Qualified Health Center (FQHC) services.

This SPA's approval is effective March 1, 2016, as requested by the State.

If you have any questions regarding this matter you may contact Robert Cruz at 781-335-3455 or by email at Robert.Cruz@cms.hhs.gov.

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

Enclosure

**TRANSMITTAL AND NOTICE OF APPROVAL
OF STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION**1. TRANSMITTAL NUMBER:
16-015

2. STATE: CT

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES4. PROPOSED EFFECTIVE DATE:
March 1, 2016

5. TYPE OF STATE PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
Sections 1905(2)(C) and 1905(bb) of the Social Security Act7. FEDERAL BUDGET IMPACT:
a. FFY 2016 \$0
b. FFY 2017 \$0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A Page 1
Attachment 3.1-B Page 1
Addendum Page 1c to Attachments 3.1-A and 3.1-B
Addendum Page 1d to Attachments 3.1-A and 3.1-B
Addendum Page 1k to Attachment 4.19-B Page 1
Addendum Pages 5, 5a, 5b, and 5c to Attachment 4.19-B
Deleted9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR
ATTACHMENT (If applicable)Attachment 3.1-A Page 1
Attachment 3.1-B Page 1
Addendum Page 1c to Attachments 3.1-A and 3.1-B
New
New
New
Addendum to Attachment 4.19-B Page 1(b)

10. SUBJECT OF AMENDMENT: Effective March 1, 2016, SPA 16-015 amends Attachments 3.1-A and 3.1-B of the Medicaid State Plan to update the description of coverage of Federally Qualified Health Center (FQHC) services. The SPA also amends Attachment 4.19-B of the Medicaid State Plan to clarify that FQHCs are reimbursed an all-inclusive encounter rate per client in accordance with a prospective payment system pursuant to 42 USC 1396a (bb) and to delineate the process by which an FQHC may apply for an adjustment of its encounter rate based upon a change in scope of services. This SPA is designed to make the Medicaid State Plan language more comprehensive, as required by CMS in accordance with the companion letter to approved SPA 13-003.

11. GOVERNOR'S REVIEW (Check One):

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☐ OTHER, AS SPECIFIED:12. SIGNATURE OF STATE AGENCY OFFICIAL:
/s/

13. TYPED NAME: Roderick L. Bremby

14. TITLE: Commissioner

15. DATE SUBMITTED: March 31, 2016

16. RETURN TO:

State of Connecticut
Department of Social Services
55 Farmington Avenue – 9th floor
Hartford, CT 06105
Attention: Ginny Mahoney**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: March 31, 2016

18. DATE APPROVED: October 15, 2018

PLAN APPROVED – ONE COPY ATTACHED19. EFFECTIVE DATE OF APPROVED MATERIAL:
March 1, 201620. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME: Richard R. McGreal

22. TITLE: Associate Regional Administrator, Division of Medicaid and
Children's Health Operations, Boston Regional Office

23. REMARKS: The state and CMS agreed to the following pen and ink changes to the Form 179. Please see the following page.

Box 8

Attachment 3.1-A Page 1

Attachment 3.1-B Page 1

Addendum Page 1c to Attachments 3.1-A and 3.1-B

Addendum Page 1d to Attachments 3.1-A and 3.1-B

Addendum Page 1k to Attachment 4.19-B Page 1

Addendum Pages 5, 5a, 5b, and 5c to Attachment 4.19-B

Deleted

Box 9

Attachment 3.1-A Page 1

Attachment 3.1-B Page 1

Addendum Page 1c to Attachments 3.1-A and 3.1-B

New

New

New

Addendum to Attachment 4.19-B Page 1(b)

State: CONNECTICUT**AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
CATEGORICALLY NEEDY GROUP(S): ALL**

1. Inpatient hospital services other than those provided in an institution for mental diseases.

☒ Provided: ☐ No limitations ☒ With limitations*☐ Not provided.

2. a. Outpatient hospital services.

☒ Provided: ☐ No limitations ☒ With limitations*☐ Not provided.

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State Plan).

☐ Provided: ☐ No limitations ☐ With limitations*☒ Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

☒ Provided: ☐ No limitations ☒ With limitations*☐ Not provided.

3. Other laboratory and x-ray services.

☒ Provided: ☒ No limitations ☐ With limitations*☐ Not provided.

*Description provided on attachment.

TN # 16-015Approval Date 10/15/18Effective Date: 3-1-16

Supersedes

TN # 11-009

State: CONNECTICUT**AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL**

-
-
1. Inpatient hospital services other than those provided in an institution for mental diseases.
☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.
2. a. Outpatient hospital services.
☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.
- b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State Plan).
☐ Provided: ☐ No limitations ☐ With limitations*
☒ Not provided.
- c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).
☒ Provided: ☐ No limitations ☒ With limitations*
☐ Not provided.
3. Other laboratory and x-ray services.
☒ Provided: ☒ No limitations ☐ With limitations*
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*Description provided on attachment.

TN # 16-015Approval Date 10/15/18Effective Date: 3-1-16

Supersedes

TN # 11-009

State: CONNECTICUTAMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
CATEGORICALLY NEEDY GROUP(S): ALL

2. a. **Outpatient Hospital Services.** Outpatient hospital services are provided in accordance with 42 CFR 440.20.

Covered services in outpatient psychiatric hospitals include, but are not limited to, (i) routine outpatient, (ii) intensive outpatient, (iii) day treatment, (iv) partial hospitalization, and (v) other services authorized in accordance with state law within the scope of the hospital's license, or, for hospitals operated by the Department of Mental Health and Addiction Services, other services authorized in accordance with state law.

No more than one (1) psychiatric/psychological reevaluation per year per hospital for the same recipient, which may be exceeded by prior authorization based on medical necessity. For hospitals operated by the Department of Mental Health and Addiction Services, no more than one (1) psychiatric / psychological evaluation per performing provider, per episode of care for the same recipient, but no more frequently than one per year, which may be exceeded by prior authorization based on medical necessity.

- b. **Rural Health Clinic Services.** There are no Rural Health Clinics in Connecticut.

State: CONNECTICUT
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
CATEGORICALLY NEEDY GROUP(S): ALL

c. Federally Qualified Health Center (FQHC) Services

- (1) General. Federally Qualified Health Center (FQHC) services are defined in section 1905 (a) (2) (C) of the Social Security Act (the Act). FQHC services include services provided by physicians, nurse practitioners, physician assistants, nurse midwives, clinical psychologists, licensed clinical social workers, and other ambulatory services included in the state plan. FQHC services also include services and supplies that are furnished incident to professional services furnished by a physician, physician assistant, nurse practitioner, or nurse midwife.

Encounters with more than one health professional for the same type of service and multiple interactions with the same health professional that take place on the same day constitute a single encounter except when the patient after the first interaction, suffers illness or injury requiring additional diagnosis and treatment. Medicaid pays for one medical encounter, one behavioral health encounter and one dental encounter per day.

Limitations on other ambulatory services furnished in the FQHC are the same limitations as defined for those services in the state plan.

- (2) Dental Services Provided by FQHCs. The following additional provisions apply for dental services provided by FQHCs:
- A. Nonemergency dental services provided by FQHCs require prior authorization, except for diagnostic, prevention, basic restoration procedures and nonsurgical extractions that are consistent with standard and medically necessary dental practices.
 - B. FQHC dental clinics must be licensed under Regulations of Connecticut State Agencies Sections 19-13-D45 to 19-13-D53, inclusive.
 - C. The Department will only pay for orthodontia for individuals under twenty-one (21) years of age.
 - D. Services must meet the requirements of 42 CFR 440.100 and are limited to the dental provider's scope of practice.

3. Other Laboratory and X-Ray Services. No limitation on services.

State: CONNECTICUT

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S): ALL

2. a. **Outpatient Hospital Services.** Outpatient hospital services are provided in accordance with 42 CFR 440.20.

Covered services in outpatient psychiatric hospitals include, but are not limited to, (i) routine outpatient, (ii) intensive outpatient, (iii) day treatment, (iv) partial hospitalization, and (v) other services authorized in accordance with state law within the scope of the hospital's license, or, for hospitals operated by the Department of Mental Health and Addiction Services, other services authorized in accordance with state law.

No more than one (1) psychiatric/psychological reevaluation per year per hospital for the same recipient, which may be exceeded by prior authorization based on medical necessity. For hospitals operated by the Department of Mental Health and Addiction Services, no more than one (1) psychiatric / psychological evaluation per performing provider, per episode of care for the same recipient, but no more frequently than one per year, which may be exceeded by prior authorization based on medical necessity.

- b. **Rural Health Clinic Services.** There are no Rural Health Clinics in Connecticut.

State: CONNECTICUT

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S): ALL

c. Federally Qualified Health Center (FQHC) Services

- (1) General. Federally Qualified Health Center (FQHC) services are defined in section 1905 (a) (2) (C) of the Social Security Act (the Act). FQHC services include services provided by physicians, nurse practitioners, physician assistants, nurse midwives, clinical psychologists, licensed clinical social workers, and other ambulatory services included in the state plan. FQHC services also include services and supplies that are furnished incident to professional services furnished by a physician, physician assistant, nurse practitioner, or nurse midwife.

Encounters with more than one health professional for the same type of service and multiple interactions with the same health professional that take place on the same day constitute a single encounter except when the patient after the first interaction, suffers illness or injury requiring additional diagnosis and treatment. Medicaid pays for one medical encounter, one behavioral health encounter and one dental encounter per day.

Limitations on other ambulatory services furnished in the FQHC are the same limitations as defined for those services in the state plan.

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- A. Nonemergency dental services provided by FQHCs require prior authorization, except for diagnostic, prevention, basic restoration procedures and nonsurgical extractions that are consistent with standard and medically necessary dental practices.
 - B. FQHC dental clinics must be licensed under Regulations of Connecticut State Agencies Sections 19-13-D45 to 19-13-D53, inclusive.
 - C. The Department will only pay for orthodontia for individuals under twenty-one (21) years of age.
 - D. Services must meet the requirements of 42 CFR 440.100 and are limited to the dental provider's scope of practice.

3. Other Laboratory and X-Ray Services. No limitation on services.

TN # 16-015
Supersedes
TN # NEW

Approval Date 10/15/18 Effective Date: 03-01-2016

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Connecticut

Outpatient Hospital Reimbursement Limitation

For any covered outpatient hospital service, only to the extent an outpatient hospital clinic visit is paid using a daily visit billing/revenue center code or similar methodology where the billing/revenue center code includes reimbursement to the hospital for all outpatient hospital clinic services provided on a date of service to the same beneficiary: (1) no more than one visit per day may be paid to the same outpatient hospital clinic; (2) no more than one visit of each type per day per beneficiary for physical therapy, occupational therapy, speech and language pathology or audiology services; and (3) payment for individual, group, family or multiple-family psychotherapy is limited to one visit of each type per day per beneficiary. However, the limit described in the previous sentence does not apply to: (i) outpatient psychiatric clinic services at acute care hospitals, (ii) public or private freestanding psychiatric hospitals, (iii) publicly operated psychiatric outpatient hospital clinics, or (iv) services where payment is not made using a code that includes all outpatient hospital clinic services provided on a date of service to the same beneficiary. When applicable, this limit simply reflects the billing requirement that the hospital may bill the same visit code or similar code only once per day for the same beneficiary.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Connecticut

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 on or before December 31st 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 improve in each measure. The tiers will be adjusted each year to account for variation in past performance. Clinics performing in the 91st to 100th percentile at both baseline and measurement years will be eligible for this supplemental payment even without any improvement in a given measurement year.

2. (b) Rural Health Clinic Services. Not provided.

TN # 16-015

Supersedes

TN # 16-002

Approval Date 10/15/18

Effective Date 03-01-2016

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Connecticut

(c) **Federally Qualified Health Center (FQHC) Services.** The rate setting methodology for FQHC services conforms to the prospective payment system under Medicare, Medicaid and SCHIP Benefits Improvement and Protections Act (BIPA) of 2000.

(1) The department shall reimburse a FQHC an all-inclusive encounter rate per client encounter in accordance with a PPS as required by 42 USC 1396a (bb).

(2) The department shall establish the baseline encounter rate for each FQHC in existence during fiscal years 1999 and 2000 as follows:

- (A) Total encounters and costs shall be obtained from the annual reports submitted by the FQHC for fiscal years 1999 and 2000;
- (B) Each year's total costs shall be divided by the total encounters. The FQHC shall include the costs of all Medicaid covered services provided by the FQHC;
- (C) A two-year average of the calculated cost per encounter rates for fiscal years 1999 and 2000 will be used for each facility. The department shall determine the two-year average for each FQHC by calculating the average cost per encounter rate separately for each year, then adding the averages together and dividing by two.
- (D) For a FQHC that did not file a 1999 annual report, the baseline encounter rate shall be based upon the annual report submitted for fiscal year 2000.
- (E) For a center that first qualified as a FQHC after fiscal year 2000, the department shall determine the baseline encounter rate based upon the encounter rate established under this section for FQHCs located in the same area with similar services.
- (F) The department shall adjust annual encounter rates by applying the percentage increase in the Medicare economic index (MEI) as defined in 42 USC 1395u (i)(3) to the previous fiscal year's encounter rate in accordance with 42 USC 1396a (bb) (3) (A).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**State Connecticut**

- (G) The department may adjust the encounter rate for a change in the scope of services provided by a FQHC in accordance with section 17b-262-1001 of the Regulations of Connecticut State Agencies.
- (3) “Change in the scope of service” means a change in the type, intensity, duration or amount of services provided by a FQHC. A change in the cost of the service alone is not considered a change in the scope of service; Examples of changes in scope of services by a FQHC for which the department may adjust the encounter rate include, but are not limited to, the following:
- (A) A change in the volume or amount of services as a result of a significant expansion or reduction of an existing clinic, or the addition or discontinuance of a satellite or new site;
- (B) A change in operational costs that is attributable to capital expenditures, including new service facilities or regulatory compliance, provided that the additional costs result in a change in the volume, amount, or intensity of services. The cost of a new or expanded building alone would not necessarily qualify;
- (C) The addition or deletion of any Medicaid covered service eligible under the FQHC reimbursement program;
- (D) A HRSA-approved change in the scope of project that results in a change in the type, intensity or amount of services provided by the FQHC, provided that the change is consistent with federal and state Medicaid regulations.
- (4) In the event of a change in scope of service for which a FQHC seeks a rate adjustment, a FQHC shall submit a written request to the Commissioner that includes the following:
- (A) A description of the change in scope of services and the reason for the change;
- (B) The impact on capital and operating costs;
- (C) The requested change in rate; and
- (D) All documentation submitted to HRSA regarding a change in scope of project, if applicable.

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Connecticut**

(5) An FQHC shall file a preliminary cost report to support its request for a rate adjustment not later than 90 days after the date on which the FQHC submitted its request for a rate adjustment.

(6) If a FQHC has received approval for a change in scope of project from HRSA for which it seeks a rate adjustment for a change in scope of services, the FQHC shall submit a written request for a change in scope of service in accordance with subsection (c) of this section not later than sixty days after the FQHC has received approval from HRSA for the change in scope of project. The FQHC shall submit all documentation submitted to HRSA regarding the change in scope of project.

(7) If a FQHC is not required to file a change in scope of project with HRSA but plans an increase or decrease in services or sites to be offered by the FQHC that result in a change to the FQHC's scope of services, the FQHC shall submit a written request for a change in scope of service in accordance with subsection (c) of this section not later than sixty days after the end of the FQHC's fiscal year. A FQHC shall submit all documentation required or requested by the department with respect to the change in scope of service.

(8) Based upon the Department's review of a variety of factors and documents, including, including not limited to the FQHC's original scope of project, subsequent amendments to the scope of project, cost reports and audited financial statements, the Department may initiate a review of an FQHC to determine whether there has been a change in the scope of services by notifying the FQHC in writing and requesting documentation with respect to the scope of services. An FQHC shall submit all requested documentation not later than ninety days after receipt of written notification from the Department.

(9) In making its determination with respect to whether a FQHC's encounter rate may be adjusted based upon a change in scope of services, the department shall review the following:

- (A) The FQHC's Medicaid cost report;
- (B) The FQHC's audited financial statements; and
- (C) Any other documentation relevant to the change in scope of services.

(10) The department shall issue a decision on a request for an adjustment to the FQHC's encounter rate not later than 120 days after the date on which the FQHC submits the request to the department.

TN # 16-015
Supersedes
TN # NEW

Approval Date 10/15/18

Effective Date 03-01-2016