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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

February 13, 2019

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. 18-005, submitted to my office on March 28, 2018 and approved on January 9, 2019.

This SPA amends Attachment 4.19-B of the Medicaid State Plan it incorporates various 2018 Healthcare Common Procedure Coding System (HCPCS) changes (additions, deletions and description changes) to the physician anesthesia, office and outpatient, physician radiology and surgical fee schedules. Codes that are being added are being priced using a comparable methodology to other codes in the same or similar category. This SPA also updates the methodology for calculating the PCMH fee-for-service rate add-on amounts to reflect the National Committee for Quality Assurance (NCQA) removal of individual levels of Patient-Centered Medical Home recognition for its 2017 standards and updates specified codes that are eligible for the state's Person-Centered Medical Home fee-for-service rate add-ons.

This SPA's approval is effective January 1, 2018, as requested by the State.

Changes are reflected in the following sections of your approved State Plan:

- Attachment 4.19B, Pages l(a)i(E) and (F)

If you have any questions regarding this matter you may contact Marie DiMartino (617) 565-9157 or by e-mail at Marie.DiMartino@cms.hhs.gov

Sincerely, /S/

Richard R. McGreal
Associate Regional Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18-0005

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 SERVICES

4. PROPOSED EFFECTIVE DATE:
January 1, 2018

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

___ NEW STATE PLAN ___AMENDMENT TO BE CONSIDERED AS NEW PLAN _X_ AMENDMENT

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

6. FEDERAL STATUTE/REGULATION CITATION:
Sections 1905(a)(5) of the Social Security Act and 42 CFR 440.50 and 60

7. FEDERAL BUDGET IMPACT:
a. FFY 2018 $106,000
b. FFY 2019 $163,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Pages 1(a)i(E) and (F)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If applicable)
Attachment 4.19-B, Pages 1(a)i(E) and (F)

10. SUBJECT OF AMENDMENT: Effective January 1, 2018, SPA 18-0005 amends Attachment 4.19-B of the Medicaid State Plan as described in the cover letter to this SPA. First, it incorporates various 2018 Healthcare Common Procedure Coding System (HCPCS) changes (additions, deletions and description changes) to the physician anesthesia, office and outpatient, physician radiology and surgical fee schedules. Codes that are being added are being priced using a comparable methodology to other codes in the same or similar category. This SPA also updates the methodology for calculating the PCMH fee-for-service rate add-on amounts to reflect the National Committee for Quality Assurance (NCQA) removal of individual levels of Patient-Centered Medical Home recognition for its 2017 standards and updates specified codes that are eligible for the state's Person-Centered Medical Home fee-for-service rate add-ons.

11. GOVERNOR'S REVIEW (Check One):

_X_ 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 27, 2018

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 28 2018

18. DATE APPROVED: January 9 2019

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
January 1 2018

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: Richard R. McGreal

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health Operations

23. REMARKS:

FORM CMS-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: CONNECTICUT

(5) Physician's services – Fixed fee schedule not to exceed the Medicare physician fee schedule. The current fee schedule was set as of January 1, 2018 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 or NCQA medical home recognition under the 2017 or later NCQA standards (which do not recognize specific levels of 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,

D1206, 99160, 99161, 96127, and 99188. 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 physicians' services. For a procedure provided to a beneficiary outside of the practitioner's office 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 practitioner. The base fees vary by practitioner type (physician, nurse practitioner, or physician assistant) according to the percentage of the physician fee schedule that is paid to each practitioner type. The rate add-on is paid at the same time as the underlying claim and is scaled based on the practice's stage of Glide Path or NCQA PCMH recognition:

i. For Glide Path practices, the total payment for each procedure code listed above, including the rate add-on, is 114% of the amount in the fee schedule.

ii. For NCQA Recognition Level 2, the total payment for each procedure code listed above, including the rate add-on, is 120% of the amount in the fee schedule. This reimbursement level does not apply to providers with NCQA medical home recognition under 2017 or later standards.

iii. For NCQA Recognition Level 3 and also for any provider with NCQA medical home recognition under 2017 or later standards, the total payment for each procedure code listed above, including the rate add-on, is 124% of the amount in the fee schedule.

Supplemental Payments for PCMH Practices: For PCMH practices only, the two types of supplemental payments detailed below will be paid to PCMH practices on a retrospective annualized basis based upon an attribution methodology, where recipients will be attributed to PCMH practices 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 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. After making a selection, regardless of the sources of care received prior to their selection during the period of claims measured in an attribution cycle, the recipient will be automatically attributed to their selected practice in the next attribution cycle. However, the recipient's selection will be overridden if, after making a selection, the recipient later receives more care from another practice in the same period of claims measured, although attribution is not changed if the recipient receives care from another practitioner within the same practice. Payments will be issued retrospectively in a lump sum on an annualized