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State/Territory Name: CT

State Plan Amendment (SPA) #: 25-0022

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

March 20, 2026

Andrea Barton Reeves, JD., Commissioner
State of Connecticut
Department of Social Services
55 Farmington Avenue, 9th Floor
Hartford, CT 06105-3730

RE: Connecticut 25-0022

Dear Commissioner Reeves:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Connecticut state plan amendment (SPA) to Attachments 4.19-A and 4.19-B CT 25-0022, which was submitted to CMS on June 30, 2025. This plan amendment proposes to reimburse hospitals for sickle cell disease drugs separately from the inpatient All Patient Refined Diagnosis Related Group (APR-DRG) payment when the drugs are approved under the Cell and Gene Therapy (CGT) Access Model.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), and 1923 of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of a October 1, 2025. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Novena James-Hailey at 617-565-1291 or via email at Novena.JamesHailey@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

Enclosures

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 25-0022

2. STATE: CT

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2025

5. FEDERAL STATUTE/REGULATION CITATION
Social Security Act Sections 1905(a) (1) and 42 CFR 440.10
1905(a)(2)(A) and 42 CFR 440.20

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2026 $ 6,147,963
b. FFY 2027 $ 10,159,419

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19A Page 1 (v)
4.19B Page 1
4.19B Page 1h

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-A Page 1 (v)
4.19B Page 1
4.19B Page 1h

9. SUBJECT OF AMENDMENT
This SPA reimburses hospitals for sickle cell disease drugs separately from the inpatient All Patient Refined Diagnosis Related Group (APR-DRG) payment only when the drugs are approved under the Cell and Gene Therapy Access Model. This change is necessary to comply with the CGT Access Model requirements.

10. 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:

[redacted]

12. TYPED NAME
Andrea Barton Reeves, J.D.

13. TITLE
Commissioner

14. DATE SUBMITTED
June 28, 2025

15. RETURN TO
State of Connecticut
Department of Social Services
55 Farmington Avenue – 9th floor
Hartford, CT 06105
Attention: Ginny Mahoney

FOR CMS USE ONLY

16. DATE RECEIVED
June 30, 2025

17. DATE APPROVED
March 20, 2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
October 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS
Pen and ink changes per state request

Instructions on Back

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

2. Under the transfer payment methodology, the hospital the member is transferred from shall be reimbursed the lesser of the DRG base payment and the transfer DRG base payment. The transfer DRG base payment equals the initial DRG base payment divided by the DRG average length of stay multiplied by the sum of one plus the actual calculated length of stay not to exceed the DRG base payment.
3. The hospital to which the member is transferred shall be reimbursed the full DRG discharge payment without a reduction due to the transfer.

G. Third Party Payments

Any applicable third-party payments are treated as offsets from allowed payments.

H. Payments Outside DRG Base Payment

The following payments are made outside of, and in addition to, the DRG base payment:

1. Direct graduate medical education is reimbursed as a prospective quarterly pass through. Payment for the state fiscal year is based on the Medicaid inpatient percentage of full-time equivalent (FTE) residents multiplied by the approved amount for resident costs, as defined in this section, using the hospital's Medicare cost report, inflated by the inpatient hospital market basket published by CMS. The Medicare cost report for the period two years prior to the current state fiscal year, submitted to the Office of Health Care Access by July1st will be used in the calculations. The approved amount for resident costs is based on worksheet E-4, line 19, column 3; total days are based on worksheet S-3, part I, column 6; and the inpatient percentage is based on inpatient revenue divided by total revenue from worksheet G-2, line 28, columns 1 and 3. Behavioral health days for children under age 19 and nursery days are excluded from Medicaid days in the Medicaid inpatient percentage.
2. Organ acquisition costs for kidneys, livers, hearts, pancreas and lungs are reimbursed at the lower of the statewide average of actual average acquisition cost using the Medicare cost reports, inflated by the inpatient hospital market basket as published by CMS, or actual charges. The Medicare cost report for the period two years prior to the current state fiscal year, submitted to the Office of Health Care Access by July1st will be used in the calculations.
3. Long-Acting Reversible Contraceptives (LARCs) will be reimbursed separately from the APR-DRG payment. A separate outpatient claim may be submitted by the hospital for reimbursement under Revenue Center Code 253 in conjunction with the following codes: J7297, J7298, J7300, J7301 and J7307. Reimbursement for these codes will be based on the CMS approved outpatient hospital reimbursement methodology as described in Attachment 4.19-B.
4. Selected drugs as listed on the state's website at the following link: https://www.ctdssmap.com/CTPortal/Hospital-Modernization, will be reimbursed separately from the APR-DRG payment. A separate outpatient claim will be submitted by the hospital for reimbursement of these drugs at the Medicare rate but no less than the Actual Acquisition Cost (AAC), as of January1, 2026, and updated quarterly based on changes to the Medicare rate.

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

Overall Payment Methodology (continued)

button and click on "Hospital Outpatient Flat Fee") and is updated each January 1st from 2020 through and including January 1, 2026 with a 2.2% increase to each fee for non-governmental licensed short-term general hospitals. Such annual increase shall be applied to the rates in effect for the immediately preceding calendar year and such fees in effect as of June 30, 2026, shall remain in effect on and after July 1, 2026, unless modified by a future SPA. The rates described above are set forth in the following table by Revenue Center Code (RCC):

RCC	2020	2021	2022	2023	2024	2025	2026*
401	$151.88	$155.22	$158.64	$162.13	$165.69	$169.34	$173.06
403	$120.50	$123.16	$125.86	$128.63	$131.46	$134.36	$137.31
421	$85.83	$87.72	$89.65	$91.62	$93.63	$95.69	$97.80
423	$42.91	$43.86	$44.82	$45.81	$46.82	$47.85	$48.90
424	$85.83	$87.72	$89.65	$91.62	$93.63	$95.69	$97.80
431	$99.38	$101.57	$103.80	$106.08	$108.42	$110.80	$113.24
433	$49.69	$50.78	$51.90	$53.04	$54.21	$55.40	$56.62
434	$99.38	$101.57	$103.80	$106.08	$108.42	$110.80	$113.24
441	$108.41	$110.80	$113.24	$115.73	$118.27	$120.88	$123.53
443	$54.21	$55.40	$56.62	$57.86	$59.14	$60.44	$61.77
444	$268.78	$274.69	$280.73	$286.91	$293.22	$299.67	$306.26
769	$459.90	$470.02	$480.36	$490.93	$501.73	$512.76	$524.05
771	$2.04	$2.09	$2.13	$2.18	$2.23	$2.28	$2.33
901	$456.11	$466.14	$476.40	$486.88	$497.59	$508.54	$519.72
953	$30.66	$31.33	$32.02	$32.73	$33.45	$34.18	$34.94

* As noted above, the rate in effect as of June 30, 2026, shall remain in effect for dates of service on and after July 1, 2026, unless modified by a future SPA;

a. 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, which is updated as of the effective date listed in the applicable section of Attachment 4.19-B and is also posted to www.ctdssmap.com (select "Provider", then "Provider Fee Schedule Download", click on the "I Accept" button and then click on the applicable fee schedule as indicated in CMAP Addendum B); or

b. Other prospective payment as specified in the payment type column in CMAP Addendum B.

5. Selected drugs as listed on the state's website at the following link: https://www.ctdssmap.com/CTPortal/Hospital-Modernization will be reimbursed separately from the APR-DRG payment. A separate outpatient claim will be submitted by the hospital for reimbursement of these drugs at the Medicare rate but no less than the Actual Acquisition Cost (AAC), as of January 1, 2026, and updated quarterly based on changes to the Medicare rate.

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

The Department contracts with several 340B pharmacies, which are reimbursed at the reimbursed at the 340B actual invoice price, plus a professional dispensing fee of $10.75.

4. Federal Supply Schedule (FSS) and Federally Qualified Health Centers (FQHC) - Facilities purchasing drugs through the FSS shall be reimbursed at the lesser of methodology, described in (12)(a), above, plus the established professional dispensing fee of $10.75.

5. Drugs Purchased at Nominal Price - Facilities purchasing drugs at Nominal Price (outside of 340B or FSS) shall be reimbursed at their actual acquisition cost.

6. Selected drugs as listed on the state's website at the following link: https://www.ctdssmap.com/CTPortal/Hospital-Modernization will be reimbursed separately from the APR-DRG payment. A separate outpatient claim will be submitted by the hospital for reimbursement of these drugs at the Medicare rate but no less than the Actual Acquisition Cost (AAC), as of January 1, 2026, and updated quarterly based on changes to the Medicare rate.

7. Clotting Factors - Pharmacies and other entities dispensing Antihemophilic Factor products (Factor VII, VIII, IX and X products) will be reimbursed at the AAC plus 8 percent as reflected on the invoice submitted with the claim to the Department plus a professional dispensing fee of $10.75. Clotting factor drugs purchased by Centers of Excellence and Hemophilia Treatment Centers under the 340B program will also be reimbursed at the AAC plus 8 percent as reflected on the invoice submitted with the claim to the Department plus a professional dispending fee of $10.75.

b. Payment for the following drugs is not based on AAC.

1. Specialty Drugs - Specialty drugs, if not on the NADAC file, are reimbursed at WAC plus zero (0) percent plus a professional dispensing fee of $10.75.

2. Physician-Administered Drugs - Reimbursement rates for drugs administered by physicians and other prescribers and at clinics are set forth on the physician and clinic fee schedules, effective for services provided on or after that date, except that procedure codes may be deleted or added and priced in order to remain compliant