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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

August 19, 2013

Roderick L. Bremby, Commissioner
Department of Social Services
25 Sigourney Street
Hartford, Connecticut 06106

Dear Mr. Bremby:

We are pleased to enclose a copy of approved Connecticut State Plan Amendment (SPA) No.12-005, submitted March 30, 2012 proposing to make a number of changes the Connecticut State Plan outpatient hospital reimbursement methodology. This SPA proposes to establish rates for a Person-Centered Medical Home (PCMH) program for outpatient hospital clinics (for calendar year 2012 only, also FQHC's) that demonstrate a higher standard of person-centered primary care service delivery that qualifies for a higher reimbursement rate for specific primary care services.

This SPA has been approved effective January 1st, 2012, as requested by the State.

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

- Attachment 4.19-B, page 1
- Addendum page 2 to Attachment 4.19-B, page 1
- Addendum page 3 to Attachment 4.19-B, page 1
- Addendum page 4 to Attachment 4.19-B, page 1
- Addendum page 5 to Attachment 4.19-B, page 1
- Addendum page 6 to Attachment 4.19-B, page 1
- Addendum page 7 to Attachment 4.19-B, page 1
- Addendum page 8 to Attachment 4.19-B, page 1
- Addendum page 1c to Attachment 3.1A
- Addendum page 1c to Attachment 3.1B

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

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

cc: Kate McEvoy, Esq. Interim Director of the Division of Health Services

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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: 12-005

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: 01-01-2012

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:
Section 1905(a)(2)(a) of the Social Security Act and
42 CFR 440.20

7. FEDERAL BUDGET IMPACT:
a. FFY 2012 $52.1 million costs
b. FFY 2013 $71.8 million costs

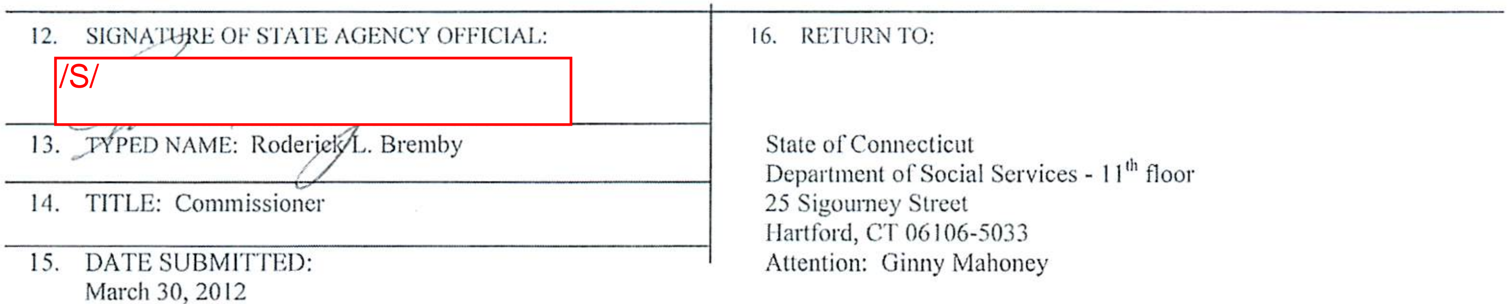
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19B Page 1
Addendum Pages 2 through 8 to Attachment 4.19B Page 1
Addendum Page 1c to Attachments 3.1A and 3.1B

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If applicable)
Attachment 4.19B Page 1
(New)
Addendum Page 1c to Attachments 3.1A and 3.1B

10. SUBJECT OF AMENDMENT: The Department of Social Services proposes to amend its Medicaid State Plan effective January 1, 2012 to make a number of changes to outpatient hospital reimbursement methodology. This SPA also proposes to establish rates for a Person-Centered Medical Home (PCMH) program for outpatient hospital clinics and (for calendar year 2012 only, also FQHCs) that demonstrate a higher standard of person-centered primary care service delivery that qualifies for a higher reimbursement for specified primary care services.

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 30, 2012

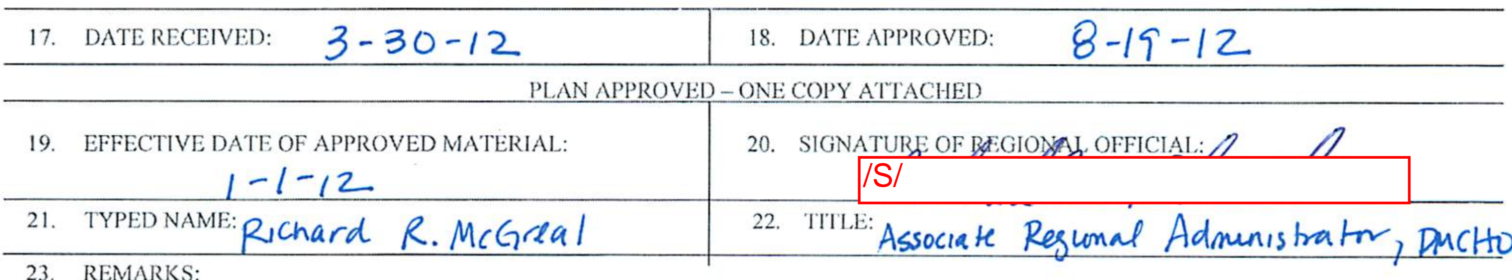
16. RETURN TO:
State of Connecticut
Department of Social Services - 11th floor
25 Sigourney Street
Hartford, CT 06106-5033
Attention: Ginny Mahoney

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 3-30-12

18. DATE APPROVED: 8-19-12

PLAN APPROVED – ONE COPY ATTACHED



19. EFFECTIVE DATE OF APPROVED MATERIAL: 1-1-12

20. SIGNATURE OF REGIONAL OFFICIAL: /S/

21. TYPED NAME: Richard R. McGreal

22. TITLE: Associate Regional Administrator, DMCHO

23. REMARKS:

FORM HCFA-179 (07-92)

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

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.

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

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.

For the period January 1, 2012 through December 31, 2012, one-time supplemental outpatient reimbursement payments shall be made for the following general acute care hospitals. This payment shall be made based on outpatient fee-for-service claims for dates of service from January 1, 2012 through December 31, 2012. The supplemental payment shall be based upon a $50.00 increase for each emergency visit (revenue center code 450) and a $30.00 increase for each urgent care and clinic visit (revenue center codes 456 and 510, respectively). These one-time payments shall not exceed the following amounts on a per hospital basis:

Hospital	Amount
BACKUS HOSPITAL, WILLIAM W.	$261,888
BRISTOL HOSPITAL	$74,610
HOCCT	$2,240,723
CCMC	$806,346
DAY KIMBALL HOSPITAL	$547,673
JOHN DEMPSEY HOSPITAL	$174,759
HARTFORD HOSPITAL	$115,476
C. HUNGERFORD HOSPITAL	$267,193
JOHNSON MEMORIAL HOSPITAL	$42,721
MIDDLESEX HOSPITAL	$220,734
MIDSTATE MEDICAL CENTER	$576,976
MILFORD HOSPITAL	$171,844
NEW MILFORD HOSPITAL	$35,561
ST. FRANCIS HOSPITAL	$409,956
ST. MARY'S HOSPITAL	$546,282
ST. RAPHAEL, HOSPITAL OF	$223,951
ST. VINCENT'S MEDICAL CENTER	$24,819
STAMFORD HOSPITAL	$171,754
WINDHAM HOSPITAL	$109,855

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

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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.

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:

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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 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 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 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.

(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.

Effective only from January 1, 2012 through December 31, 2012, Person Centered Medical Home (PCMH) practices are individual FQHC sites that have met National Committee for

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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.

Effective only from January 1, 2012 through December 31, 2012, the department offers a PCMH Glide Path program, which pays enhanced rates to FQHCs that are providing some of the additional Medicaid services required for NCQA PCMH recognition. In order to qualify for Glide Path, an FQHC 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.

Effective only from January 1, 2012 through December 31, 2012, FQHCs participating in PCMH and Glide Path may be eligible for an add-on to the encounter rate for encounters that included one or more procedures corresponding to the procedure codes on the physician fee schedule listed below.

1. Glide Path and PCMH Rate Add-On to the FQHC Encounter Rate

Effective only from January 1, 2012 through December 31, 2012, the rate add-on is paid in addition to the FQHC encounter rate for encounters 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 FQHC encounter that was provided to a beneficiary outside of the FQHC 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 FQHC. 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 FQHCs, the total payment for each encounter that included one or more procedures corresponding to the procedure codes listed above, including the rate add-on, is 103.6% of the encounter rate.

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

ii. For NCQA PCMH Level 2, the total payment for each encounter that included one or more procedures corresponding to the procedure codes listed above, including the rate add-on, is 105.3% of the encounter rate.
iii. For NCQA PCMH Level 3, the total payment for each encounter that included one or more procedures corresponding to the procedure codes listed above, including the rate add-on, is 106.3% of the encounter rate.

For FQHCs with encounter rates under $131, the rate add-ons described above will be increased by 0.4% for each category (104% of the encounter rate for Glide Path, 105.7% of the encounter rate for PCMH Level 2, and 106.7% of the encounter rate for PCMH Level 3). For FQHCs with encounter rates over $150, the rate add-ons described above will be decreased by 0.3% for each category (103.3% of the encounter rate for Glide Path, 105% of the encounter rate for PCMH Level 2, and 106% of the encounter rate for PCMH Level 3).

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

(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.

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State: CONNECTICUT

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

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2. a. Outpatient Hospital Services

   1. No more than one (1) visit per day to the same outpatient clinic, except for outpatient psychiatric clinic services at acute care hospitals and public or private freestanding psychiatric hospitals. Outpatient hospital psychiatric services are claimed on a service specific basis.

   2. No more than one (1) psychiatric/psychological reevaluation per year per hospital for the same recipient.

   b. Rural Health Clinic Services

   There are no Rural Health Clinics in Connecticut.

   c. Federally Qualified Health Center (FQHC)

   1. The Department subjects nonemergency dental services provided by federally qualified health centers to prior authorization. Nonemergency services that are exempt from prior authorization include diagnostic, prevention, basic restoration procedures and nonsurgical extractions that are consistent with standard and medically necessary dental practices.

   2. Federally qualified health center dental clinics must be licensed under Regulations of Connecticut State Agencies Sections 19-13-D45 to 19-13-D53, inclusive.

   3. The Department will only pay for orthodontia for individuals under twenty-one (21) years of age.

   4. Services must meet the requirements of 42 CFR 440.100 and are limited to the dental provider's scope of practice.

   5. The limitations in Section 10(b) and 10(c) which are found in Addendum Page 8a to Attachment 3.1-A also apply.

3. Other Laboratory and X-Ray Services

   No limitation on services.

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State: CONNECTICUT

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

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2. a. Outpatient Hospital Services

1. No more than one (1) visit per day to the same outpatient clinic, except for outpatient psychiatric clinic services at acute care hospitals and public or private freestanding psychiatric hospitals. Outpatient hospital psychiatric services are claimed on a service specific basis.

2. No more than one (1) psychiatric/psychological reevaluation per year per hospital for the same recipient.

b. Rural Health Clinic Services

There are no Rural Health Clinics in Connecticut.

c. Federally Qualified Health Center (FQHC)

1. The Department subjects nonemergency dental services provided by federally qualified health centers to prior authorization. Nonemergency services that are exempt from prior authorization include diagnostic, prevention, basic restoration procedures and nonsurgical extractions that are consistent with standard and medically necessary dental practices.

2. Federally qualified health center dental clinics must be licensed under Regulations of Connecticut State Agencies Sections 19-13-D45 to 19-13-D53, inclusive.

3. The Department will only pay for orthodontia for individuals under twenty-one (21) years of age.

4. Services must meet the requirements of 42 CFR 440.100 and are limited to the dental provider's scope of practice.

5. The limitations in Section 10(b) and 10(c) which are found in Addendum Page 8a to Attachment 3.1-B also apply.

3. Other Laboratory and X-Ray Services

No limitation on services.