CT SPA 18-0020

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
John F. Kennedy Federal Building
Boston, Massachusetts 02203

Boston Regional Operations Group

April 4, 2019

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

Dear Mr. Bremby:

On March 22, 2019, our Central Office sent you a letter approving your proposed State Plan amendment (SPA) No. 18-0020. This letter transmits via e-mail the Transmittal and Notice of Approval State Plan Material (CMS-179) and the approved State Plan pages.

In SPA 18-0020, the State proposes to update Connecticut's reimbursement methodology for physician-administered drug to comport with the Covered Outpatient Drugs final rule with comment period (COD final rule) (CMS-2345-FC) (81 FR 5170) published on February 1, 2016.

This SPA also satisfies CMS' companion letter for SPA 17-0015 requesting the state to update their physician-administered drug methodology. SPA 18-0020 revised physician-administered drug methodology to 100% of the Medicare Average Sale Price (ASP).

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

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

- Attachment 4.19-B Page 1(a)I(E)
- Attachment 4.19-B Page 1(b)i
- Attachment 4.19-B Page 1(b)ii
- Attachment 4.19-B Page 1(c)
- Attachment 4.19-B Page 1(c)i
- Attachment 4.19-B Page 2

If you have any questions regarding this matter you may contact Marie DiMartino (978) 330-8063 or by e-mail at Marie.DiMartino@cms.hhs.gov

Sincerely,

/S/

Francis T. McCullough
Director
Division of Medicaid Field Operations-East

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: 18-0020

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: March 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) and (9) of the Social Security Act and 42 CFR 440.50 and 440.90

7. FEDERAL BUDGET IMPACT:
a. FFY 2018 $258,000
b. FFY 2019 $452,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Page 1(a)i(E)
Attachment 4.19-B, Pages 1(b)i, 1(b)ii, 1(c), 1(c)i
Attachment 4.19-B, Page 2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If applicable)
Attachment 4.19-B, Page 1(a)i(E)
Attachment 4.19-B, Pages 1(b)i, 1(b)ii, 1(c) , 1(c)i
Attachment 4.19-B, Page 2

10. SUBJECT OF AMENDMENT: Effective March 1, 2018, SPA 18-0020 amends Attachment 4.19-B of the Medicaid State Plan to update the reimbursement methodology for physician-administered drugs, immune globulins, vaccines and toxoids. Specifically, the methodology is revised to 100% of the January 2018 Medicare Average Sales Price (ASP) Drug Pricing file. For procedure codes that are not priced on the January 2018 Medicare ASP Drug Pricing File and procedure codes that are described as "unclassified," the drug will be priced at the lowest of: the usual and customary charge to the public or the actual submitted ingredient cost; the National Average Drug Acquisition Cost (NADAC) established by CMS; the Affordable Care Act Federal Upper Limit (FUL); or the Wholesale Acquisition Cost (WAC) plus zero (0) percent when no NADAC is available for the specific drug. Additional details are described in the cover letter for this SPA.

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 27 2018

18. DATE APPROVED: March 22, 2019

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
March 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL:
/S/

21. TYPED NAME: Francis T. McCullough

22. TITLE: Director
Division of Medicaid Field Operations East

23. REMARKS: Pen and ink change to box 8 and 9 adding Attachment 4.19-B page 2 approved by the State per Pharmacy request on 3/19/19

FORM CMS-179 (07-92)

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

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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 March 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,

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Connecticut

(b) Dialysis Clinics: The current fee schedule was set as of March 1, 2018 and is effective for services provided on or after that date. All rates are published at www.ctdssmap.com.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Connecticut

(c) Family Planning Clinics: The current fee schedule was set as of March 1, 2018 and is effective for services provided on or after that date. All rates are published at www.ctdssmap.com.

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

(d) Medical Clinics: The current fee schedule was set as of March 1, 2018 and is effective for services provided on or after that date. All rates are published at www.ctdssmap.com. Rates are the same for private and governmental providers.

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

(e) Behavioral Health Clinics:

(e.1) **Private Behavioral Health Clinics.**

The current fee schedule was set as of March 1, 2018 and is effective for services on or after that date. Fees for services provided to individuals 18 years of age and over will be 95% of the published fee.

Effective January 1, 2012 the Department established a separate fee schedule for private behavioral health clinics that meet special access and quality standards and such fees are higher than the fees available to clinics that do not meet such special standards. These clinics must accept all (100%) telephonic and walk-in referrals that present during business hours. All referrals must be screened by a trained intake worker or clinician and triaged to determine whether the referral is emergent, urgent or routine. A clinician must evaluate a client who presents at the clinic with an emergent condition within two (2) hours. Clients that undergo telephonic or walk-in screening and are determined to be in urgent need of services must be offered an appointment for an urgent face-to-face clinical evaluation with a clinician to take place within two (2) calendar days of the screening. Clients that undergo telephonic or walk-in screening and are determined to have routine needs must be offered an appointment for a routine face-to-face clinical evaluation with a clinician to take place within 14 calendar days of the screening. These clinics must have at least nine (9) extended hours per week beyond routine business hours of 8:00 AM to 5:00 PM. Providers that are designated Enhanced Care Clinics and have a valid Letter of Agreement with the Department that holds them accountable to the quality standards and access standards receive the enhanced rate for all routine outpatient services provided. The state monitors the access standards on a routine basis and provides access standard reports to the providers on a quarterly basis. The state has established a process for providers to submit corrective action plans (CAPs) if they do not meet the access standards for any reason except in increase in volume in excess of 20% compared to the same quarter of the previous year. All Enhanced Care Clinics must electronically register appointments made with the Administrative Services Organization (ASO).

with HIPAA. The physician and clinic 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 Services" then to "Fee Schedule Download". All governmental and private providers are reimbursed according to the same fee schedule.

Physician-administered drugs are priced using the Medicare Average Sales Price (ASP) Drug Pricing File for January of the year in which the drugs are provided, which is updated effective January 1st of each calendar year. For procedure codes that are not priced on the Medicare ASP Drug Pricing File and for procedure codes that are described as "unclassified," the drug is priced at the lowest of:

- the usual and customary charge to the public or the actual submitted ingredient cost;
- the National Average Drug Acquisition Cost (NADAC) established by the Centers for Medicare and Medicaid Services;
- the Affordable Care Act Federal Upper Limit (FUL); or
- the Wholesale Acquisition Cost (WAC) plus zero (0) percent when no NADAC is available for a specific drug.

1. Investigational Drugs - Investigational drugs are not covered.

2. Outpatient Hospital Drugs – The majority of codes for drugs provided in outpatient hospital settings are reimbursed through the ambulatory payment classification system (APC).

3. Drugs Dispensed by IHS Tribal Facilities –The IHS Tribal Facility does not dispense covered outpatient drugs.

4. Drugs Dispensed by Institutional or Long-Term Care Pharmacies – These drugs are reimbursed at the lesser of methodology for retail community pharmacies described in (12)(a), plus a professional dispensing fee of $10.75.

7. Over-the-Counter Drugs - Non-legend drugs are reimbursed at average wholesale price (AWP). No professional dispensing fee will be paid for over-the-counter drugs.