Table of Contents

State/Territory Name: Connecticut

State Plan Amendment (SPA) #: 23-0012

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

July 1, 2024

Andrea Barton Reeves, J.D., Commissioner
Department of Social Services
55 Farmington Avenue
Hartford, CT 06105

Re: Connecticut State Plan Amendment (SPA) 23-0012

Dear Commissioner Reeves:

We reviewed your proposed Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 23-0012. This amendment continues certain flexibilities previously approved in Disaster Relief State Plan Amendments and a Section 1135 Disaster Relief waiver.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act Sections 1905(a)(2)(C),(3),(4)(E)&(F), (5), (6), (7), (9), (10), (13), (18), (21), 1915(k) and 42 CFR 440.30, 50, 60, 70, 90,100, 130(d), 441 Subpart K 1905(a)(19) and 1915(g) and 42 CFR 440.169 and 441.18. This letter informs you that Connecticut's Medicaid SPA Transmittal Number 23-0012 was approved on July 1, 2024, with an effective date of May 12, 2023.

Enclosed are copies of the Form CMS-179 and the approved SPA pages to be incorporated into the Connecticut State Plan.

If you have any questions, please contact Marie DiMartino at (617) 565-9157 or via email at Marie.DiMartino@cms.hhs.gov.

Sincerely,

[redacted]

Falecia M. Smith, Acting Director
Division of Program Operations

Enclosures

DEPARTMENT OF HEALTH ANDHUMAN 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: 23-0012

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
May 12, 2023

5. FEDERAL STATUTE/REGULATION CITATION
Social Security Act Sections 1905(a)(2)(C),(3),(4)(E)&(F), (5), (6), (7), (9), (10), (13), (18), (21), 1915(k) and 42 CFR 440.30, 50, 60, 70, 90, 100, 130(d), 441 Subpart K

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 5,719,612
b. FFY 2024 $ 15,893,362

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Add. p. 1d(i) to Att 3.1-A & 3.1-B; Add. p.11a toAtt.4.19-B p.1(NEW)
Add. pp. 1(d), 2(g) 3, 7 to Att. 3.1-A & 3.1-B
Supp. pp. 2gg-2mm to Add. p. 12 to Att. 3.1-A & 3.1-B (NEW)
Att. 3.1-K, pp. 5, 9, 10, 11; Add.p.11 to Att.4.19-B p.1
Att.4.19B,pp.1(a)i(E),1(a)iii-vi,1(b)i -1(b)ii,1(c),1(c)i-vii,1(e),16,2b
Supp.1e-1i toAtt.4.19Bp4; 4.19-B p1(a)ix-1(a)x(NEW)

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Add. pp. 1(d), 2(g) 3, 7 to Att. 3.1-A & 3.1-B
Att. 3.1-K, pp. 5, 9, 10, 11; Add.p.11 to Att.4.19-B p.1

Att.4.19B,pp.1(a)i(E),1(a)iii-vi,1(b)i-1(b)ii,1(c),1(c)i -1(c)vii, 1(e),16,2b

9. SUBJECT OF AMENDMENT
Effective May 12, 2023, the first day after the expiration of the COVID-19 federal Public Health Emergency (PHE), as detailed in the cover letter, this SPA continues certain flexibilities previously approved in disaster relief SPAs and a section 1135 disaster relief waiver.

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:

11. SIGN [redacted]

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

13. TITLE
Commissioner

14. DATE SUBMITTED
June 28, 2023

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 28, 2023

17. DATE APPROVED
July 1, 2024

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
May 12, 2023

19. SIGNATURE OF APPROVING OFFICIAL [redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Falecia M. Smith

21. TITLE OF APPROVING OFFICIAL
Acting Director
Division of Program Operations

22. REMARKS

Instructions on Back

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, nurse midwife, clinical psychologists, marriage and family therapists, mental health counselors or licensed clinical social workers.

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.

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.

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

3. **Other Laboratory and X-Ray Services.** No limitation on services. Pursuant to 42 CFR 440.30(d), the state covers laboratory tests (including self-collected tests authorized by the FDA for home use) that do not meet one or more conditions specified in 42 CFR 440.30(a) and (b).

c. Family Planning Services

The Department will not pay for any procedures or services of an unproven, experimental or research nature.

5. Physician Services

a. The Department will not pay for any procedures or services of an unproven, experimental or research nature.

b. The Department shall pay for surgical services necessary to treat morbid obesity when another medical illness is caused by, or is aggravated by, the obesity. Such illness shall include illnesses of the endocrine system or cardio-pulmonary system, or physical trauma associated with the orthopedic system. For the purposes of this section, "morbid obesity" means "morbid obesity" as defined by the International Classification of Diseases (ICD), as amended from time to time.

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

c. The Department will not pay for cosmetic surgery.

d. The Department will not pay for an office visit for the sole purpose of the patient obtaining a prescription where the need for the prescription has already been determined.

e. The Department will not pay for cancelled office visits or for appointments not kept.

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

d. Medical Clinics licensed by the Department of Public Health. Limitation: No more than one (1) visit per day of the same type of service per recipient.

e. Rehabilitation Clinics accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) on the Joint Commission on Accreditation of Healthcare Organization (JCAHO). A copy of the medical director's current physician license and statement accepting full professional responsibility for the services are also required.

f. Methadone Maintenance Clinics licensed by the Department of Public Health.

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

13.d. Rehabilitative Services

MENTAL HEALTH SERVICES PROVIDED BY CLINICS (42 C.F.R. § 440.130(d))

A. Overview

Mental health services provided by clinics (specifically, mental health services provided by behavioral health clinics and all behavioral health services provided by medical clinics and rehabilitation clinics, each as defined below) are provided as part of a continuum of services and are available to all Medicaid-eligible individuals of all ages for whom mental health services are medically necessary. For medical clinics and rehabilitation clinics, this section applies only to mental health services provided by those clinics. Note that substance use disorder (SUD) services are described in a separate section within this rehabilitative services benefit category section of the Medicaid State Plan. Services must be medically necessary and recommended by an independent licensed practitioner, as defined below, to promote the maximum reduction of symptoms and/or restoration of an individual to the best possible functional level according to an individualized treatment plan, which includes, as applicable, assistance with recovery from one or more mental health conditions and/or restoration of an individual to a normal developmental trajectory.

B. Service Components

1. **Assessment and Individualized Plan Development**

    a. Component Description: The development of an individualized person-centered treatment plan addresses the individual's diagnosis or diagnoses and assessed needs, including the type, amount, frequency, and duration of services to be provided, and the specific goals and objectives developed based on the evaluation and diagnosis to attain or maintain a member's achievable level of independent functioning.

The individualized treatment plan must be person-centered and developed in collaboration with the individual and any other persons chosen by the individual to participate in the development of the treatment plan, including family members, when appropriate and when for the direct benefit of the beneficiary.

b. Qualified Practitioners: Independent licensed practitioners (defined below); and associate licensed practitioners (defined below) or graduate level intern, working under the direct supervision of a physician or independent licensed practitioner, who is otherwise qualified to perform services under the applicable clinic licensure category. The independent licensed practitioner must also sign each assessment and treatment plan performed by an associate licensed practitioner or graduate-level intern.

2. **Therapy**

a. Component Description: Individual, group, couples, and family therapy, or any combination thereof, as medically necessary based on the beneficiary's treatment plan, to address an individual's major lifestyle, attitudinal, and behavioral problems. This component focuses on symptom reduction associated with the individual's diagnosis(es), stabilization and restoration to the person's best possible functional level, including use of appropriate evidence-informed practices. Collateral contact is permitted as needed to address the therapeutic goals of the Medicaid beneficiary receiving treatment. Any family therapy must be for the direct benefit of the beneficiary.

b. Qualified Practitioners: Independent licensed practitioners; and associate licensed practitioners or non-licensed or non-certified individuals, working under the direct supervision of an independent licensed practitioner.

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

3. **Health Services and Medication Management**

   a. Component Description: This component includes any combination of the following as medically necessary for each person: health assessments, health monitoring, health education requiring a medical license (in one of the categories of qualified practitioners for this service) for an individual or group session with members to learn specific ways of coping and progressing in their recovery. Psychotropic and other medication management (including prescribing, monitoring, administration and observation of self-administration, as applicable) are provided to the extent medically necessary and as permitted under state law.

   b. Qualified Practitioners: Physicians, advanced practice registered nurses, physician assistants, registered nurses, and licensed practical nurses, each of whom must be licensed under state law and acting within the person's scope of practice under state law.

4. **Service Coordination**

   a. Component Description: This component includes assisting with coordination of services necessary to meet the individual's needs and service planning for Medicaid-covered services, and referral and linkage to other Medicaid-covered services. Service coordination entails the coordination by the provider with Medicaid-covered services outside of the services performed by the provider or in the provider's facility, including medical care. Standalone service coordination is covered for beneficiaries under age 19. Otherwise, it is covered as a component of another applicable service.

   b. Qualified Practitioners: Independent licensed practitioners; associate licensed practitioners; registered nurses; licensed practical nurses; and non-licensed or non-certified individuals. All individuals other than independent licensed practitioners must work under the supervision of an independent licensed practitioner or other applicable qualified supervising practitioner as set forth below in the definition for each category of practitioner.

5. Intermediate Intensity Services

a. Component Description: This component includes: each of the following two types of service packages, each of which is a more intensive combination of the service components defined above in this section than for routine outpatient services (i.e., Assessment and Individualized Plan Development, Therapy, Health Services and Medication Management, and Service Coordination): (i) intensive outpatient services (IOP), which is an integrated program of outpatient psychiatric services that are more intensive treatment than routine outpatient psychiatric services and (ii) partial hospitalization program (PHP) which has the same meaning as provided in sections 1861(ff)(1) to 1861(ff)(3), inclusive, of the Social Security Act.

b. Qualified Practitioners: Independent licensed practitioners; and associate licensed practitioners or non-licensed or non-certified individual, working under the direct supervision of an independent licensed practitioner.

C. Provider Qualifications

1. Provider Entity Qualifications

Mental health services provided by clinics must be provided by an entity licensed by the state as a behavioral health clinic (also known as mental health and substance abuse clinics, psychiatric outpatient clinics, outpatient psychiatric clinics, or similar names), medical clinic, or rehabilitation clinic or be provided by a clinic operated by the Department of Mental Health and Addiction Services. To the extent applicable, each provider entity must obtain all licenses applicable to all age cohorts (children, adults, or both) that it serves.

For services provided outside the state in accordance with 42 C.F.R. § 431.52, the provider entity and each practitioner employed by or working under contract to the entity must have comparable credentials in the state in which the facility is located.

Qualified providers under this section do not include inpatient or outpatient hospitals or individually enrolled physicians or other licensed practitioners because mental health services performed by those providers remain separately covered in each of the applicable benefit categories for those providers, as detailed in sections 1, 2, 5, and 6, as applicable, of Attachment 3.1-A of the Medicaid State Plan.

2. Practitioner Qualifications

Mental health services detailed in this section must be performed by practitioners employed by or under contract to qualified provider entities who meet the following qualifications:

a. General Qualifications: To the extent applicable for each service component, as set forth above, eligible practitioners include licensed and non-licensed professional staff, who are employed or contracted to an eligible provider entity, are at least 18 years of age, have at least a high school diploma or equivalent general education degree (GED) or such additional education necessary to provide specific services, plus other required qualifications as set forth by state law or other requirements for each category of service provided.

b. Supervision: Anyone providing mental health services other than an Independent Licensed Practitioner must be under the direct supervision of an Independent Licensed Practitioner to the full extent necessary based on the services provided and the person's qualifications. The Independent Licensed Practitioner must perform required supervision and must accept primary responsibility for the mental health services performed by the applicable practitioner.

c. Independent Licensed Practitioner: Any of the following categories of individuals who are licensed under state law and acting within their scope of practice under state law: physicians, licensed psychologists, licensed clinical social workers, licensed marital and family therapists, licensed professional counselors, licensed alcohol and drug counselors, advanced practice registered nurses, or physician assistants.

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

d. Associate Licensed Practitioner: Any of the following categories of individuals who are licensed under state law and acting within their scope of practice under state law, including applicable supervision requirements: licensed master social worker, licensed professional counselor associate, licensed marital and family therapy associate, and any other comparable associate licensure for a category of practitioner included in the definition of independent licensed practitioner in which the associate license requires, at a minimum, that the individual has received a graduate degree that is required for the comparable independent licensed practitioner category. The associate licensed practitioner works under the supervision of an applicable independent licensed practitioner as set forth in the applicable scope of practice.

e. Non-licensed or non-certified individuals: Any individual who does not meet the requirements for any of the other practitioner categories set forth in this section and who works under the supervision of an independent licensed practitioner.

f. Graduate-Level Intern: Must be actively enrolled in an accredited graduate degree program at an accredited college or university that: (1) once completed, would satisfy the graduate education requirements for one or more categories of independent licensed practitioner and (2) requires students to participate in intern placements for clinical training in the provision of behavioral health services. The graduate-level intern must receive weekly clinical supervision from an independent licensed practitioner who is the intern's site-supervisor and also supervision from the intern's graduate degree program. This supervision must be conducted in accordance with the standards outlined by the sponsoring graduate degree program and any relevant graduate education accreditation body or bodies applicable to the degree program.

g. Licensed Practical Nurse: Licensed under state law as a licensed practical nurse and working under the person's scope of practice in accordance with state law.

h. Registered Nurse: Licensed under state law as a registered nurse and working under the person's scope of practice in accordance with state law.

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

D. Excluded Services

The following services are excluded from coverage:

1. Components that are not provided to or directed exclusively for the treatment of the Medicaid eligible individual;
2. Services or components of services of which the basic nature is to supplant housekeeping or basic services for the convenience of a person receiving covered services; or
3. Services that are solely vocational or recreational.

State: CONNECTICUT
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
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B. FQHC dental clinics must be licensed.

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

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

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

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State: CONNECTICUT
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The individualized treatment plan must be person-centered and developed in collaboration with the individual and any other persons chosen by the individual to participate in the development of the treatment plan, including family members, when appropriate and when for the direct benefit of the beneficiary.

b. Qualified Practitioners: Independent licensed practitioners (defined below); and associate licensed practitioners (defined below) or graduate level intern, working under the direct supervision of a physician or independent licensed practitioner, who is otherwise qualified to perform services under the applicable clinic licensure category. The independent licensed practitioner must also sign each assessment and treatment plan performed by an associate licensed practitioner or graduate-level intern.

2. **Therapy**

a. Component Description: Individual, group, couples, and family therapy, or any combination thereof, as medically necessary based on the beneficiary's treatment plan, to address an individual's major lifestyle, attitudinal, and behavioral problems. This component focuses on symptom reduction associated with the individual's diagnosis(es), stabilization and restoration to the person's best possible functional level, including use of appropriate evidence-informed practices. Collateral contact is permitted as needed to address the therapeutic goals of the Medicaid beneficiary receiving treatment. Any family therapy must be for the direct benefit of the beneficiary.

b. Qualified Practitioners: Independent licensed practitioners; and associate licensed practitioners or non-licensed or non-certified individuals, working under the direct supervision of an independent licensed practitioner.

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

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   a. Component Description: This component includes any combination of the following as medically necessary for each person: health assessments, health monitoring, health education requiring a medical license (in one of the categories of qualified practitioners for this service) for an individual or group session with members to learn specific ways of coping and progressing in their recovery. Psychotropic and other medication management (including prescribing, monitoring, administration and observation of self-administration, as applicable) are provided to the extent medically necessary and as permitted under state law.

   b. Qualified Practitioners: Physicians, advanced practice registered nurses, physician assistants, registered nurses, and licensed practical nurses, each of whom must be licensed under state law and acting within the person's scope of practice under state law.

4. **Service Coordination**

   a. Component Description: This component includes assisting with coordination of services necessary to meet the individual's needs and service planning for Medicaid-covered services, and referral and linkage to other Medicaid-covered services. Service coordination entails the coordination by the provider with Medicaid-covered services outside of the services performed by the provider or in the provider's facility, including medical care. Standalone service coordination is covered for beneficiaries under age 19. Otherwise, it is covered as a component of another applicable service.

   b. Qualified Practitioners: Independent licensed practitioners; associate licensed practitioners; registered nurses; licensed practical nurses; and non-licensed or non-certified individuals. All individuals other than independent licensed practitioners must work under the supervision of an independent licensed practitioner or other applicable qualified supervising practitioner as set forth below in the definition for each category of practitioner.

5. Intermediate Intensity Services

a. Component Description: This component includes: each of the following two types of service packages, each of which is a more intensive combination of the service components defined above in this section than for routine outpatient services (i.e., Assessment and Individualized Plan Development, Therapy, Health Services and Medication Management, and Service Coordination): (i) intensive outpatient services (IOP), which is an integrated program of outpatient psychiatric services that are more intensive treatment than routine outpatient psychiatric services and (ii) partial hospitalization program (PHP) which has the same meaning as provided in sections 1861(ff)(1) to 1861(ff)(3), inclusive, of the Social Security Act.

b. Qualified Practitioners: Independent licensed practitioners; and associate licensed practitioners or non-licensed or non-certified individual, working under the direct supervision of an independent licensed practitioner.

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

C. Provider Qualifications

1. Provider Entity Qualifications

Mental health services provided by clinics must be provided by an entity licensed by the state as a behavioral health clinic (also known as mental health and substance abuse clinics, psychiatric outpatient clinics, outpatient psychiatric clinics, or similar names), medical clinic, or rehabilitation clinic or be provided by a clinic operated by the Department of Mental Health and Addiction Services. To the extent applicable, each provider entity must obtain all licenses applicable to all age cohorts (children, adults, or both) that it serves.

For services provided outside the state in accordance with 42 C.F.R. § 431.52, the provider entity and each practitioner employed by or working under contract to the entity must have comparable credentials in the state in which the facility is located.

Qualified providers under this section do not include inpatient or outpatient hospitals or individually enrolled physicians or other licensed practitioners because mental health services performed by those providers remain separately covered in each of the applicable benefit categories for those providers, as detailed in sections 1, 2, 5, and 6, as applicable, of Attachment 3.1-A of the Medicaid State Plan.

2. Practitioner Qualifications

Mental health services detailed in this section must be performed by practitioners employed by or under contract to qualified provider entities who meet the following qualifications:

a. General Qualifications: To the extent applicable for each service component, as set forth above, eligible practitioners include licensed and non-licensed professional staff, who are employed or contracted to an eligible provider entity, are at least 18 years of age, have at least a high school diploma or equivalent general education degree (GED) or such additional education necessary to provide specific services, plus other required qualifications as set forth by state law or other requirements for each category of service provided.

b. Supervision: Anyone providing mental health services other than an Independent Licensed Practitioner must be under the direct supervision of an Independent Licensed Practitioner to the full extent necessary based on the services provided and the person's qualifications. The Independent Licensed Practitioner must perform required supervision and must accept primary responsibility for the mental health services performed by the applicable practitioner.

c. Independent Licensed Practitioner: Any of the following categories of individuals who are licensed under state law and acting within their scope of practice under state law: physicians, licensed psychologists, licensed clinical social workers, licensed marital and family therapists, licensed professional counselors, licensed alcohol and drug counselors, advanced practice registered nurses, or physician assistants.

d. Associate Licensed Practitioner: Any of the following categories of individuals who are licensed under state law and acting within their scope of practice under state law, including applicable supervision requirements: licensed master social worker, licensed professional counselor associate, licensed marital and family therapy associate, and any other comparable associate licensure for a category of practitioner included in the definition of independent licensed practitioner in which the associate license requires, at a minimum, that the individual has received a graduate degree that is required for the comparable independent licensed practitioner category. The associate licensed practitioner works under the supervision of an applicable independent licensed practitioner as set forth in the applicable scope of practice.

e. Non-licensed or non-certified individuals: Any individual who does not meet the requirements for any of the other practitioner categories set forth in this section and who works under the supervision of an independent licensed practitioner.

f. Graduate-Level Intern: Must be actively enrolled in an accredited graduate degree program at an accredited college or university that: (1) once completed, would satisfy the graduate education requirements for one or more categories of independent licensed practitioner and (2) requires students to participate in intern placements for clinical training in the provision of behavioral health services. The graduate-level intern must receive weekly clinical supervision from an independent licensed practitioner who is the intern's site-supervisor and also supervision from the intern's graduate degree program. This supervision must be conducted in accordance with the standards outlined by the sponsoring graduate degree program and any relevant graduate education accreditation body or bodies applicable to the degree program.

g. Licensed Practical Nurse: Licensed under state law as a licensed practical nurse and working under the person's scope of practice in accordance with state law.

h. Registered Nurse: Licensed under state law as a registered nurse and working under the person's scope of practice in accordance with state law.

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

D. Excluded Services

The following services are excluded from coverage:

1. Components that are not provided to or directed exclusively for the treatment of the Medicaid eligible individual;
2. Services or components of services of which the basic nature is to supplant housekeeping or basic services for the convenience of a person receiving covered services; or
3. Services that are solely vocational or recreational.

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

Community First Choice State Plan Option Pursuant to Section 1915(k) of the Social Security Act

Two individuals may share an Attendant.
The State assumes the cost for a comprehensive background check on all Attendants that an individual seeks to hire. The individual receives a copy of the results in order to make an informed decision as to whether to hire the Attendant. If any criminal record is found, the individual may elect to hire the Attendant but must sign a waiver stating that he or she is aware of and understands the criminal findings.

The CFC participant will include the cost of workers compensation coverage for their employees as part of their individual budget in accordance with Attachment 4.19-B of the Medicaid State Plan.

Limits on amount, duration or scope: The department assigns an overall budget based on need grouping that is determined by algorithm. Natural supports are based on the individual's functional assessment, which will take into consideration the availability of natural supports. Natural supports are identified during the person-centered service planning process and utilized when available to the individual. Natural supports are defined as voluntary unpaid care provided on a regular and consistent basis by a parent, spouse, or other person. Although beneficial for service delivery for this category of service to be provided in person, to the extent clinically appropriate for each individual based on that person's circumstances, service delivery may be provided virtually, subject to the state's approval.

Transitional Services
Service Definition: Transitional services are non-recurring services for individuals who are transitioning from a nursing facility, institution for mental diseases, or intermediate care facility for individuals with intellectual disabilities to a home and community-based setting where the individual resides. Allowable transitional services are those necessary to enable a person to establish a basic household and may include:

- essential household furnishings and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items and bed/bath linens;
- transportation expenses to pay for trips associated with locating housing;
- set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
- services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy.

Limit on amount and duration of scope: Transitional services funds are furnished only to the extent that they are necessary as determined through the service plan development process and

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D. Voluntary training on how to hire, manage or dismiss staff

Training

Service Definition: Training will be offered to participants via one-on-one (1:1) assistance or web-based training. 1:1 assistance will be fulfilled through a self-hired support and planning coach. The web-based option may be fulfilled through free online e-learning modules through the State of Connecticut Connect-Ability website or other on-line training programs.

Support and Planning Coach Qualifications:
• Be 21 years of age;
• have a completed criminal background check;
• have a completed registry check;
• demonstrate ability, experience and/or education to assist the individual and/or family in the hiring, management of personal care assistance and with other community services detailed in the participant's plan;
• demonstrate competence in knowledge of DSS policies and procedures: abuse/neglect; incident reporting; human rights and confidentiality; handling fire and other emergencies, prevention of sexual abuse, knowledge of approved and prohibited physical management techniques;
• demonstrate understanding of the role of the service, of advocacy, person-centered planning, and community services;
• demonstrate understanding of self-hiring protocols and DSS fiscal management policies;
• have certification as Aging and Disability Specialist or person centered planning certificate and continue to meet annual recertification in person centered planning requirements; and
• Other qualifications as determined by the participant.

Experience: Five years of experience in a professional capacity in a disability or health organization or five years of personal experience managing supports and services in the community either as a person with a disability or as a parent of a child with a disability, except that parents cannot provide this service for their own children. College training may be substituted for the General Experience on the basis of fifteen (15) semester hours equaling one half (1/2) of a year of experience to a maximum of four (4) years for a Bachelor's degree. A Master's degree in public health, social work, or rehabilitation may be substituted for General Experience.

Limit on amount and scope: This service is limited to an annual limit of $500 per participant.

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6. Home and Community-Based Services (HCBS) Setting

CFC services will be provided in residential settings that have been determined by the State to have met the home and community-based setting requirements outlined in 42 C.F.R. § 441.530. CFC residential settings include individual homes or apartments that meet CFC residential criteria.
CFC services are not available in any of the settings outlined in Section 1915(k)(1)(A)(ii) of the Social Security Act. These include nursing facilities, institutions for mental diseases, and intermediate care facilities for individuals with intellectual disabilities. In addition, CFC services are not available in group homes that serve individuals with developmental disabilities, group homes that serve people with psychiatric conditions, or assisted living environments. CFC services are also not provided in non-residential provider-owned or operated settings. These settings are explicitly excluded either because the state has determined that these settings do not meet the settings requirements in 42 CFR 441.530.

7. Assessment of Need– Who is conducting and frequency

A DSS nurse or social worker performs a level of care screening evaluation of each applicant. Level of Care will be met if the individual requires the level of care provided in a hospital, nursing facility, an intermediate care facility for individuals with intellectual disabilities (ICF/ID), an institution providing psychiatric services for individuals under 21, or an institution for mental diseases for individuals age 65 and older. Confirmation of a participant's level of care is determined by information gathered by assessors at contracted entities during initial assessment and annual re-assessment via face-to-face interviews utilizing the Universal Assessment (UA). Both assessment and re-assessment include a thorough evaluation of the client's individual circumstances. Although beneficial for the assessment to be conducted in person, to the extent clinically appropriate for each individual based on that person's circumstances, the state will allow, with state approval, the use of telemedicine or other information technology medium in lieu of a face-to-face assessment in accordance with 42 C.F.R. § 441.535. The individual is provided with the opportunity for an in-person assessment in lieu of one performed via telemedicine. For every assessment, the individual receives appropriate supports to facilitate an assessment appropriate to the individual's circumstances, including access to on-site support staff during the assessment.

The UA is based on the InterRAI tool. The UA is a validation tool used to confirm level of care and calculate a level of need based on the identified needs of the participant. The UA assesses a participants Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) needs as well as taking into account their health, rehabilitation needs, and their natural supports.

Assessor qualifications: The assessor who conducts the assessments and provides ongoing monitoring is either a registered nurse (RN) licensed in Connecticut or a social services worker

who is a graduate of an accredited four-year college or university. The nurse or social services worker has a minimum of two years of experience in health care or human services, but may substitute a bachelor's degree in nursing, health, social work, gerontology or a related field for one year of experience.

Additional qualifications of assessors:
The assessor must demonstrate interviewing skills that include: the professional judgment to probe as necessary to uncover underlying concerns of the applicants; demonstrate ability to establish and maintain empathetic relationships; experience in conducting social and health assessments; knowledge of human behavior, family/caregiver dynamics, human development and disabilities; awareness of community resources and services; and the ability to understand and apply complex service reimbursement issues.

8. Person-Centered Service Plan (PCSP)

Assessors complete the assessment which confirms level of care and level of need. The need grouping is associated with a budget allocation. The assessment produces a person-centered summary that the individual may use to help inform their care planning process. Assessors are responsible for informing individuals about the care planning process, how to use an individual budget, the various services available, the assessment summary, and the option to either develop a care plan independently, with support of family and/or friends, or with a Support and Planning Coach. Each individual has a Person-Centered Service Plan (PCSP). A PCSP is intended to meet all of the individual needs of the participant. This planning process, and the resulting person-centered service plan, provides the framework for the individual to achieve personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare. The individual has the ability to select from the services offered within CFC as well as the existing Medicaid State Plan based on the areas of need determined in the UA aligned with their personal goals. The PCSP addresses individual's' need for assistance with Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and health-related tasks through hands-on assistance, supervision, and/or cueing. It also addresses the acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks. Although beneficial for person-centered care planning to be provided in person, to the extent clinically appropriate for each individual based on that person's circumstances, person-centered care planning may be provided virtually, subject to the state's approval.

(3) Other Laboratory and X-ray Services –

- Laboratory Services: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of laboratory services. The agency's fee schedule rates were set as of May 12, 2023 and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download." The Department reviews Medicare rate changes annually to ensure compliance with federal requirements.

(3) Other Laboratory and X-ray Services (cont'd)

- X-ray Services provided by independent radiology centers: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of x-ray services provided by independent radiology centers. The agency's fee schedule rates were set as of January 1, 2023. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download." Select the "Independent Radiology" fee schedule, which displays global fees, including both the technical and professional components of each fee.

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(5) Physician's services – Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of physician's services. The agency's fee schedule rates were set as of May 12, 2023 and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the applicable 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, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99406, 99407, 99408, 99409, 99411, 99412, 99417, 99374, 99377, 99379, 99380, 96110, 99050, 99051, 99053, D0145,

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(ii) Naturopaths – The current fee schedule was set as of January 1, 2012 and is effective for services provided on or after that date. The fee schedule for naturopaths 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." Rates are the same for private and governmental providers and are published at www.ctdssmap.com.

(iii) Nurse practitioners – 90% of physician fees as referenced in (5) above, except for physician-administered drugs and supplies, COVID-19 vaccines and their administration, and services rendered by certified registered nurse anesthetists, which are reimbursed at 100% of the physician fees.

Nurse practitioner groups and individual nurse practitioners are eligible to participate in the Person-Centered Medical Home (PCMH) initiative detailed in (5) above under Physician's Services. Nurse practitioner services within PCMH practices run by nurse practitioners are authorized by Section 1905(a)(6) (services by other licensed practitioners). Nurse practitioners working in a physician group or a solo physician practice are eligible to participate in the PCMH initiative as part of the physician group or solo physician practice under the Physician's Services section of the State Plan.

(iv) Dental Hygienists - 90% of the department's fees for dentists as referenced in (10) below).

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(v) Licensed behavioral health practitioners to include licensed clinical social workers, licensed marital and family therapists, licensed professional counselors, and licensed alcohol and drug counselors. The fee schedule for licensed behavioral health practitioners 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." The agency's rates were set as of November 17, 2021 and are effective for services on or after that date. Rates are the same for private and governmental providers and are published at www.ctdssmap.com.

(vi) Physician assistants – 90% of the department's fees for physicians, as referenced in (5) above, except for physician-administered drugs and supplies and COVID-19 vaccines and their administration, which are reimbursed at 100% of the physician fees.

Physician assistants working in a physician group or a solo physician practice are eligible to participate in the Person-Centered Medical Home (PCMH) initiative detailed in (5) above under Physician's Services as part of the physician group or solo physician practice under the Physician's Services section of the State Plan in Section (5) above.

(vii) Acupuncturists - 100% of physician fees as noted in (5) above. The current fee schedule was set as of October 1, 2021 and is effective for services provided on or after that date. The fee schedule for acupuncturists 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.

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7. Home Health Services –

(a) Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area are provided with limitations.

(b) Home health aide services provided by a home health agency with limitations.

(c) Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility are provided with limitations.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of home health services provided by a home health agency listed above in (a), (b), and (c). The agency's fee schedule rates were set as of May 12, 2023 and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the applicable fee schedule.

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Rate Increases and Supplemental Payments to Enhance, Expand, and/or Strengthen Home and Community-Based Services (HCBS), Implemented in accordance with the state's Spending Plan for Implementation of the American Rescue Plan Act of 2021, Section 9817, as updated (ARPA HCBS Spending Plan): General Requirements: All rate increases set forth below apply only to providers actively enrolled on the date payment is issued. As applicable, payments may be proportionally reduced to the extent necessary to remain within available funding approved under the ARPA HCBS Spending Plan.
In addition to the fee schedule rate, effective August 1, 2021, the state pays a value-based payment rate add-on of up to 1% of the applicable rate for any home health service set forth in (a), (b), and (c) above in accordance with the following:

The first 1% performance payment will be paid on or before March 31, 2022 and is effective for and based on expenditures from August 1, 2021 through February 28, 2022 for each qualifying provider that meets the following standards:
(a) Participation in the Department of Social Services Racial Equity Training – 80% of all supervisors employed by the agency must complete the first training by February 1, 2022; and,
(b) Provider has Data Sharing Agreement executed with the state's Health Information Exchange (HIE) Payment methodology.

The second 1% performance payment will be paid on or before July 31, 2022 and is effective for and based on expenditures from March 1, 2022 through June 30, 2022 for each qualifying provider that meets the following standards:
(a) Participation in Department of Social Services Racial Equity Training – 80% of all supervisors employed by the agency must complete the second training and 50% of all other staff employed by the agency must complete the first training; and,
(b) Signing, at a minimum, the HIE Empanelment Use Case; and,
(c) Action plan detailing how the provider sends their client roster in an approved format to the state's HIE.

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Home Health Services (Continued)

(d) Medical supplies, equipment and appliances suitable for use in the home – Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of medical supplies, equipment and appliances suitable for use in the home. The agency's fee schedule rates were set as of January 1, 2023 and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the applicable fee schedule. Over-the-counter products provided by pharmacies are reimbursed at Average Wholesale Price (AWP).

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(8) Private duty nursing services – Not Provided.

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(b) Dialysis Clinics: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of dialysis clinic services. The agency's fee schedule rates were set as of May 12, 2023, and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the applicable fee schedule.

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(c) Family Planning Clinics: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of family planning clinic services. The agency's fee schedule rates were set as of May 12, 2023 and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the applicable fee schedule.

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(d) Medical Clinics: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of medical clinic services. The agency's fee schedule rates were set as of May 12, 2023, and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the applicable fee schedule.

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(e) Behavioral Health Clinics: (e.1) **Private Behavioral Health Clinics**[intentionally deleted]

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[intentionally deleted]

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(e.2) **Public Behavioral Health Clinics**. [intentionally deleted]

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(f) Rehabilitation Clinics:

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of rehabilitation clinic services. The agency's fee schedule rates were set as of May 12, 2023 and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the applicable fee schedule.

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Dental Services:

(a) Dental Services Provided to Adults: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of dental services provided to adults. The agency's fee schedule rates were set as of May 12, 2023 and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the applicable fee schedule.

(b) Dental Services Provided to Children: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of dental services provided to children. The agency's fee schedule rates were set May 12, 2023 and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider," then to "Provider Fee Schedule Download," then select the applicable fee schedule.

Mental Services Provided by Clinics - Rehabilitative Services 42 CFR 440.130(d)

Mental Health Services Provided by Privately Operated Behavioral Health Clinics and Behavioral Health Services Provided by Medical Clinics and Rehabilitation Clinics. Except as otherwise noted in the Medicaid State Plan, the state-developed fee schedule is the same for both governmental and private providers. The agency's fee schedule rates for mental health services provided by privately operated behavioral health clinics and behavioral health services provided by medical clinics and rehabilitation clinics in the rehabilitative services benefit category were set as of May 12, 2023 and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: https://www.ctdssmap.com. From this web page, go to "Provider" then to "Provider Fee Schedule Download," then select the applicable fee schedule (for mental health services provided by behavioral health clinics, select the behavioral health clinic fee schedule and refer to the applicable codes as provided by freestanding clinics; for mental health services provided by medical clinics, select the medical clinic fee schedule and refer to the codes for mental health services; and for mental health services provided by rehabilitation clinics, select the rehabilitation clinic fee schedule and refer to the codes for mental health services).

There is a separate fee schedule for private behavioral health clinics providing behavioral health services under the rehabilitative services benefit category 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 5:00PM. 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

Mental Services Provided by Clinics - Rehabilitative Services 42 CFR 440.130(d)

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).

Publicly Operated Behavioral Health Clinics. Behavioral health clinic services pursuant to 42 C.F.R. § 440.90 as described in Attachments 3.1-A and Attachment 3.1-B and associated addendum pages are reimbursed by Medicaid when provided by the Department of Mental Health and Addiction Services (DMHAS) in a public behavioral health clinic to a Medicaid beneficiary and at least one outpatient behavioral health clinic service for that day is recorded for the beneficiary in the clinic. Reimbursement for private behavioral health clinics is described above. Documentation of services shall be maintained in the beneficiary's service record. Payment for outpatient services delivered by DMHAS in public behavioral health clinics may not duplicate Medicaid payments for other Medicaid covered services.

1. **Definitions applicable to this section:**
   - **1.1** Facility – a public behavioral health clinic where behavioral health clinic services are delivered as described in Attachment 3.1A and 3.1B. Each facility has its own NPI number.
   - **1.2** Rate Period – is the state fiscal year (SFY) beginning July 1 and ending June 30 of each year.
   - **1.3** Cost Report – CMS-approved Medicaid cost report for Public Outpatient clinic services.
   - **1.4** Reimbursable Cost – shall include salaries and wages, fringe benefits and indirect cost.
   - **1.5** Indirect Cost – indirect cost is calculated using the HHS approved indirect cost rate
   - **1.6** Unit of Service - outpatient behavioral health clinic services pursuant to 42 C.F.R. § 440.90 described in Attachments 3.1-A and 3.1-B and associated addendum pages.

2. **Interim Rates:**

Interim rates for outpatient services provided by DMHAS in public behavioral health clinics shall be updated annually. Interim rates for outpatient services in public behavioral health clinics will be computed using settled costs from the prior state fiscal year for public outpatient services provided to Medicaid clients in a public behavioral health clinic rounded up to the nearest $10. The cost reimbursement methodology is described below in section "4. Cost Reimbursement Methodology" and the timing of settlement is described below in section "5. Cost Settlement." Interim rates are provisional in nature, pending the completion of cost reconciliation and cost settlement for the rate period, as noted below in section "5. Cost Settlement." Payments for public outpatient services provided by DMHAS behavioral health clinics will not duplicate payments made under Medicaid for other covered services.

3. Cost Reports:
Final reimbursement for outpatient services provided by DMHAS in public behavioral health clinics is based on the certified by DMHAS cost report.
DMHAS shall complete and certify a cost report for outpatient services delivered by DMHAS in public behavioral health clinics during the previous State fiscal year. The reimbursable outpatient cost shall be determined in accordance with principles described in Medicare Provider Reimbursement Manual and OMB Circular A-87. Cost reports are due to the Department of Social Services no later than 10 months following the close of the State fiscal year during which the costs included in the cost report were incurred. The cost report shall include certification of funds by DMHAS. Submitted cost reports are subject to desk review by the Department of Social Services or its designee. Desk review shall be completed within 8 months following the receipt of cost reports.

4. Cost Reimbursement Methodology:
In determining Medicaid allowable costs for providing outpatient services delivered in public behavioral health clinics, the following elements shall be included and calculations shall be made:

4.1 Subtotal direct cost net of physician costs shall include salary and wages and fringe benefits. Direct cost shall not include room and board charges.
4.2 Adjusted subtotal direct costs net of physician costs removes any federal reimbursement from the Subtotal direct cost net of physician costs (item 4.1).
4.3 Indirect cost shall be calculated by applying the HHS approved indirect cost rate for the cost reporting period to the adjusted subtotal direct costs net of physician costs (item 4.2).
4.4 Total costs net of physician costs is the sum of the adjusted subtotal direct costs net of physician costs (item 4.2) and the indirect cost applicable to direct cost (item 4.3).
4.5 Outpatient program costs net of physician costs shall be calculated by applying outpatient allocation base, a result of the CMS approved RMTS, to the total direct cost net of physician costs (item 4.4).

4.6 Medicaid penetration rate is the percent of Medicaid outpatient services of the total outpatient services recorded for the cost reporting period in DMHAS' WITS services report or its replacement.
4.7 Medicaid allowable direct cost net of physician costs is the result of applying the Medicaid penetration rate (item 4.6) to the outpatient program cost net of physician costs (item 4.5).
4.8 Medicaid allowable physician costs include salary and wages, fringe benefits, and indirect costs. It shall be calculated by multiplying the physician's reported hours of Medicaid visits and their hourly salary. Outpatient fringe benefits are calculated by taking their outpatient salary over their total annual salary, and applying the percentage to their fringe benefits. Physician indirect cost shall be calculated by applying the HHS approved indirect cost rate for the cost reporting period to sum of outpatient salary and fringe benefits.
4.9 Medicaid allowable certified public expenditure (CPE) is the sum of the total Medicaid allowable direct cost net of physician costs (item 4.7) and the total Medicaid allowable physician cost (item 4.8).

5. Cost Settlement: DMHAS claims paid at the interim rates for outpatient services delivered in public behavioral health clinics during the reporting period, as documented in the MMIS, will be compared to the total Medicaid allowable cost for outpatient services delivered in public behavioral health clinics based on the CMS approved cost report identified as per item (4). DMHAS interim rate claims for outpatient services delivered in public behavioral health clinics will be adjusted in aggregate. This results in cost reconciliation. Reconciliation will occur within 24 months of the end of the reporting period contained in the submitted cost report. If it has been determined that an overpayment has been made, the Department of Social Services will return the federal share of the overpayment. If the actual, certified Medicaid allowable costs of outpatient services delivered in public behavioral health clinics exceed the interim Medicaid rates, the Department of Social Services will submit claims to CMS for the underpayment. Cost settlement will occur within the timelines set forth in 42 CFR 433 Subpart F. Connecticut will not modify the CMS-approved scope of costs, time study methodology or the annual cost report methodology without CMS approval.

6. Audit: All supporting accounting records, statistical data and all other records related to the provision of the outpatient services delivered by DMHAS in public behavioral health clinics is subject to audit. If an audit discloses discrepancies in the accuracy and/or allowances of actual direct or indirect costs or statistical data as submitted for each fiscal year by DMHAS, the Department of Social Services' Medicaid payment rate for the said period is subject to adjustment.

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(21) Pediatric and family nurse practitioners – are paid off of the physician fee schedule at 90% of physician fees as referenced in (5) above, except for physician-administered drugs and supplies and COVID-19 vaccines and their administration, which are reimbursed at 100% of the physician fees. Pediatric and family nurse practitioner groups and individual pediatric and family nurse practitioners are eligible to participate in the Person-Centered Medical Home (PCMH) initiative detailed in (5) above under Physician's Services. Pediatric and family nurse practitioner services within PCMH practices run by pediatric and family nurse practitioners are authorized by Section 1905(a)(21) (services by certified pediatric and family nurse practitioners). Pediatric and family nurse practitioners working in a physician group or a solo physician practice are eligible to participate in the PCMH initiative as part of the physician group or solo physician practice under the Physician's Services section of the State Plan.

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(17) Nurse-mid wife services - are paid off of the physician fee schedule at 100% of physician fees, as referenced in (5) above.

(18) The Medicaid Hospice rates are set prospectively by CMS based on the methodology used in setting Medicare Hospice rates, which are adjusted to disregard the cost offsets attributable to Medicare coinsurance amounts. Hospice payment rates are also adjusted for regional differences in wages, using indices published in the Federal Register and daily Medicaid hospice payment rates announced through CMS's memorandum titled "Annual Change in Medicaid Hospice Payment Rates—ACTION". COVID-19 vaccines and their administration are paid off of the physician fee schedule at 100% of physician fees, as referenced in (5) above, regardless of whether the individual is otherwise receiving services from the hospice provider. The hospice fee schedule 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. For clients living in a nursing facility, the per diem nursing facility rate will equal 95% of the rate for that nursing home under the Medicaid program.