STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 23-V: HIPAA Compliance Billing Code and Reimbursement Updates: Physician Office & Outpatient Fee Schedule and Updates to the Ambulatory Surgical Centers Fee Schedule

The State of Connecticut Department of Social Services (DSS) proposes to submit the following Medicaid State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS).

Changes to Medicaid State Plan

Effective on or after April 1, 2023, SPA 23-V will amend Attachment 4.19-B of the Medicaid State Plan to make the updates detailed below. First, this SPA ill incorporate various federal Healthcare Common Procedure Coding System (HCPCS) updates (additions, deletions and description changes) to the physician office and outpatient fee schedule. Codes that are being added are being priced using a comparable methodology to other codes in the same or similar category. DSS is making these changes to ensure that this fee schedule remains compliant with the Health Insurance Portability and Accountability Act (HIPAA).

Second, this SPA incorporates increased rates for the following long-acting reversible contraceptive (LARC) devices on the physician office and outpatient fee schedule, which applies to providers who bill for these LARC devices under the physician office and outpatient fee schedule. This change is necessary to properly reimburse providers for the increased acquisition cost of these devices and to ensure continued access to the devices.

Code	Description	Old Rate	New Rate
J7296	Kyleena 19.5 mg	$1049.24	$1101.70
J7298	Mirena 52 mg	$1049.24	$1101.70
J7301	Skyla 13.5 mg	$873.67	$917.35

Third, currently procedure code 99418 is currently listed on the physician office and outpatient fee schedule as manually price (MP) and this procedure will be priced as follow replacing the manually priced notation:

Procedure Code	Description	Current Rate	New Rate

99418	Prolonged inpatient or observation service, each 15 minutes of total time beyond	MP	$18.56

Fourth, in accordance with the existing federally approved methodology for physician-administered drugs in the Medicaid State Plan, this SPA will update the reimbursement methodology for various physician-administered drugs as detailed below. The purpose of these changes is to align with this federally required and approved methodology. Specifically, several physician-administered drugs that were previously listed as manually priced will be assigned actual reimbursement rates. The revised reimbursement rates will be updated to 100% of the January 2023 Medicare Average Sales Price (ASP) Drug Pricing file for physician-administered drugs, immune globulins, vaccines, and toxoids.

For any physician administered drug procedure codes that are not priced on the January 2023 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
- Wholesale Acquisition Cost (WAC) plus zero (0) percent when no NADAC is available for the specific drug.

Finally, the Freestanding Ambulatory Surgical Center (ASC) fee schedule will be updated with the following: (1) addition of procedure code G0330 - Facility services dental rehab, which will be priced using a methodology consistent with other codes on the same fee schedule and (2) rate increase of bariatric surgery procedure code 43775 (sleeve gastrectomy) from the current rate of $3,717.35 to the new rate of $6,374.82.

Fee schedules are published at this link: https://www.ctdssmap.com, then select "Provider", then select "Provider Fee Schedule Download," then select the applicable fee schedule.

Fiscal Impact

DSS anticipates that the HIPAA compliance updates to the physician office and outpatient fee schedules will have minimal financial impact, since utilization of the added codes is likely to shift utilization from similarly priced codes.

DSS estimates that increasing the rates for the select LARC devices on the physician office and outpatient fee schedule will increase annual aggregate expenditures by approximately $20,099 in State Fiscal Year (SFY) 2023 and $124,210 in SFY 2024.

DSS estimates that the change of pricing the procedure code 99418 from manually priced to an actual reimbursement rate is estimated to have no financial impact, since there is no utilization of the impacted code.

This proposed changes to manually priced physician-administered drug to an actual rate are estimated to have minimal financial impact, since there was minimal utilization of the impacted codes in SFY 2022.

DSS estimates that the proposed changes to the ASC fee schedule will increase annual aggregate expenditures by approximately $208,315 in SFY 2023 and $1,287,389 in SFY 2024.

Obtaining SPA Language and Submitting Comments

The proposed SPA is posted on the DSS website at this link: https://portal.ct.gov/DSS/Health-And-Home-Care/Medicaid-State-Plan-Amendments. The proposed SPA may also be obtained at any DSS field office, at the Town of Vernon Social Services Department, or upon request from DSS (see below).

To request a copy of the SPA from DSS or to send comments about the SPA, please email: Public.Comment.DSS@ct.gov or write to: Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105. Please reference "SPA 23-V: HIPAA Compliance Billing Code and Reimbursement Updates: Physician Office & Outpatient Fee Schedule and Updates to the Ambulatory Surgical Centers Fee Schedule".

Anyone may send DSS written comments about this SPA. Written comments must be received by DSS at the above contact information no later than April 12, 2023.

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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 ~~January~~ April 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.

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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9. Clinic services – Rates for freestanding clinics are set as follows:

(a) Ambulatory Surgical Centers: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of ambulatory surgical center services. The agency's fee schedule rates were set as of ~~January~~ April 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.