DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 18-B: Physician Reimbursement – HIPAA Update, PCMH Program Updates, and Physician Radiology Update

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 January 1, 2018, SPA 18-B will amend Attachment 4.19-B of the Medicaid State Plan as described below. This SPA will incorporate the 2018 Healthcare Common Procedure Coding System (HCPCS) (additions, deletions and description changes) to the physician anesthesia, office and outpatient, physician radiology and surgical fee schedules. 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 these fee schedules remain compliant with the Health Insurance Portability and Accountability Act (HIPAA).

This SPA also implements the following updates to the Person-Centered Medical Home (PCMH) program. This SPA updates the methodology for calculating the PCMH fee-for-service rate add-on amounts to reflect the National Committee for Quality Assurance (NCQA) removal of individual levels of Patient-Centered Medical Home recognition for its 2017 standards. Specifically, any eligible PCMH provider who meets the 2017 NCQA standards will be eligible to receive 124% of the applicable fee for each specified code. More information about the PCMH program is available at this link: http://huskyhealthct.org/providers/pcmh.html#.

This SPA also updates the procedure codes eligible for the PCMH program fee-for-service rate add-ons. The following codes are eligible for the PCMH enhanced reimbursement rates for dates of service January 1, 2018 and forward (in addition to the codes already eligible for the enhanced reimbursement rates):

- 96160* - Administration and interpretation of patient-focused health risk assessment
- 96161* - Administration and interpretation of caregiver-focused health risk assessment
- 96127 - Brief emotional or behavioral assessment
- 99188 - Application of topical fluoride

* The national code set deleted code 99420 (which is also being deleted from the PCMH language in the Medicaid State Plan by this SPA) and replaced it with codes 96160 and 96161.

Lastly, this SPA updates the reimbursement rates for select services on the physician-radiology fee schedule to ensure these rates are consistent with the standard reimbursement methodology of 57.5% of the 2007 Medicare fee schedule (or first applicable year thereafter that the code was priced by Medicare). Specifically, all codes in that fee schedule that were previously priced using a different methodology were changed to reflect this methodology. In addition, the technical and professional components of codes were removed for codes where Medicare does not list separate prices for the technical and professional components.

Fee schedules are published at this link: http://www.ctdssmap.com, then select "Provider", then select "Provider Fee Schedule Download."

Fiscal Impact

DSS estimates that the HIPAA compliant updates will increase annual aggregate expenditures by approximately $84,000 in State Fiscal Year (SFY) 2018 and approximately $208,000 in SFY 2019.

DSS estimates that the update to the physician-radiology fee schedule will increase annual aggregate expenditures by approximately $8,000 in SFY 2018 and approximately $21,000 in SFY 2019.

DSS estimates that updating the procedure codes eligible for PCMH enhanced reimbursement will reduce annual aggregate expenditures by approximately $43,000 in SFY 2018 and $85,000 in SFY 2019. It is not possible to estimate the anticipated fiscal impact of the other PCMH program change at this time.

Obtaining SPA Language and Submitting Comments

This SPA is posted on the DSS web site at the following link: http://portal.ct.gov/dss. Scroll down to the bottom of the webpage and click on "Publications" and then click on "Updates." Then click on "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 (Phone: 860-424-5067). Please

reference “SPA 18-B: Physician Reimbursement – HIPAA Update, PCMH Program Updates, and Physician Radiology Update”.

Anyone may send DSS written comments about this SPA. Written comments must be received by DSS at the above contact information no later than January 10, 2018.

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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 January 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,

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D1206, 99160, 99161, 96127, and 99188. These codes were selected to pay providers for providing a more advanced level of primary care and to encourage more providers to provide primary care to beneficiaries, which will help expand access to primary care physicians' services. For a procedure provided to a beneficiary outside of the practitioner's office in a nursing facility, rest home, or the beneficiary's home, the applicable rate add-on will be paid if the beneficiary is attributed to the practitioner. The base fees vary by practitioner type (physician, nurse practitioner, or physician assistant) according to the percentage of the physician fee schedule that is paid to each practitioner type. The rate add-on is paid at the same time as the underlying claim and is scaled based on the practice's stage of Glide Path or NCQA PCMH recognition:

i. For Glide Path practices, the total payment for each procedure code listed above, including the rate add-on, is 114% of the amount in the fee schedule.

ii. For NCQA Recognition Level 2, the total payment for each procedure code listed above, including the rate add-on, is 120% of the amount in the fee schedule. This reimbursement level does not apply to providers with NCQA medical home recognition under 2017 or later standards.

iii. For NCQA Recognition Level 3 and also for any provider with NCQA medical home recognition under 2017 or later standards, the total payment for each procedure code listed above, including the rate add-on, is 124% of the amount in the fee schedule.

Supplemental Payments for PCMH Practices: For PCMH practices only, the two types of supplemental payments detailed below will be paid to PCMH practices on a retrospective annualized basis based upon an attribution methodology, where recipients will be attributed to PCMH practices in accordance with the department's current written attribution methodology. The attribution methodology assigns recipients to primary care practitioners based on claims volume analyzed retrospectively every three calendar months. If a recipient receives care from multiple providers during a given period, the recipient is assigned to the practice that provided the plurality of care and if there is no single largest source of care, to the most recent source of care. Recipients may affirmatively select a PCMH practice as their primary care provider. After making a selection, regardless of the sources of care received prior to their selection during the period of claims measured in an attribution cycle, the recipient will be automatically attributed to their selected practice in the next attribution cycle. However, the recipient's selection will be overridden if, after making a selection, the recipient later receives more care from another practice in the same period of claims measured, although attribution is not changed if the recipient receives care from another practitioner within the same practice. Payments will be issued retrospectively in a lump sum on an annualized