

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106



Medicaid and CHIP Operations Group

September 20, 2024

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

Re: Connecticut State Plan Amendment (SPA) 24-0002

Dear Commissioner Reeves:

We reviewed your proposed Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 24-0002. This amendment updates HCPCS reimbursement to physician office & outpatient/radiology/surgery, independent radiology, MEDS, lab, adult/children dental services, audiology/speech & language, ambulatory surgical centers, rehab/medical and behavioral health clinics. This SPA also updates reimbursement to physician admin drugs; adult complex skilled nursing services; long-acting reversible contraceptives (LARCs) and adds periodontal SRP services. It also extends rate add-ons for pediatric inpatient psych and the states person centered medical homes (PCMH+) program.

We conducted our review of your submittal according to statutory requirements in Social Security Act Sections 1905(a)(3), (5), (7), and (10) and 42 CFR 440.30, 440.50, 440.70, and 440.100. This letter informs you that Connecticut's Medicaid SPA Transmittal Number 24-0002 was approved on September 20, 2024, effective January 1, 2024.

Enclosed are copies of 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,

James G. Scott, Director
Division of Program Operations

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER _____	2. STATE _____
3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT XIX XXI	
4. PROPOSED EFFECTIVE DATE	
6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars) a. FFY _____ \$ _____ b. FFY _____ \$ _____	
7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT	8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable)

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

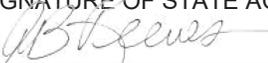
5. FEDERAL STATUTE/REGULATION CITATION

9. SUBJECT OF AMENDMENT

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. SIGNATURE OF STATE AGENCY OFFICIAL


12. TYPED NAME

13. TITLE

14. DATE SUBMITTED

15. RETURN TO

FOR CMS USE ONLY

16. DATE RECEIVED March 28, 2024	17. DATE APPROVED September 20, 2024
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PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL January 1, 2024	19. SIGNATURE OF APPROVING OFFICIAL
20. TYPED NAME OF APPROVING OFFICIAL James G. Scott	21. TITLE OF APPROVING OFFICIAL Director Division of Program Operations

22. REMARKS

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Connecticut

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

CATEGORICALLY NEEDY GROUP(S): ALL

All Medicaid claim costs for covered services will be included in the shared savings calculations described in Attachment 4.19-B, except for: hospice; long-term services and supports (LTSS), including institutional and home and community-based services; and non-emergency medical transportation (NEMT) services. Participating Entities do not need to deliver all defined benefits; rather, the cost of all benefits provided to an assigned PCMH+ member, regardless of the specific provider that performed each service, will be included in the shared savings calculation.

III. Quality Measures

In addition to providing the Enhanced Care Coordination Activities (and for Participating Entities that are FQHCs, also the Care Coordination Add-On Payment Activities), in order to be eligible to receive shared savings payments, if applicable, each PCMH+ Participating Entity must also maintain and/or improve the quality of care and care experience for beneficiaries assigned to the Participating Entity, as measured by various quality measures. Specifically, in order to be eligible to receive shared savings payments, each PCMH+ Participating Entity must meet specified standards as described in Attachment 4.19-B. The PCMH+ quality measure set contains process and outcome measures that include measures of beneficiary experience. Of those measures, a specified subset of measures will be used in calculating various payments, as described in Attachment 4.19-B. All of the quality measures and applicable quality gates have been updated as of January 1, 2024 and apply to payments and Performance Years beginning on or after that date and a description of those measures, including the use of each such measure in calculating shared savings payments, is posted to DSS's website at: <https://portal.ct.gov/DSS/Health-And-Home-Care/PCMH-Plus/Quality-Measure>, then select the applicable time period.

The quality measure set will be reviewed annually and updated as deemed necessary by DSS. Changes in the measure set will be derived from recommendations generated from the Program Evaluations for prior years.

IV.. Measures to Prevent Under-Service

Participating Entities will be disqualified from receiving shared savings payments if they demonstrate repeated or systematic failure to offer medically necessary services or manipulate their member panel, whether or not there is evidence of intentionality. DSS uses a multi-pronged approach to identify and prevent under-service of PCMH+ members. The data points that DSS monitors under this approach include, but are not limited to: PCMH+ member grievances, provider performance on quality measures (particularly preventive care service measures),

TN # 24-0002

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Supersedes

TN # 21-0010

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Connecticut

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S): ALL

All Medicaid claim costs for covered services will be included in the shared savings calculations described in Attachment 4.19-B, except for: hospice; long-term services and supports (LTSS), including institutional and home and community-based services; and non-emergency medical transportation (NEMT) services. Participating Entities do not need to deliver all defined benefits; rather, the cost of all benefits provided to an assigned PCMH+ member, regardless of the specific provider that performed each service, will be included in the shared savings calculation.

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The quality measure set will be reviewed annually and updated as deemed necessary by DSS. Changes in the measure set will be derived from recommendations generated from the Program Evaluations for prior years.

IV. Measures to Prevent Under-Service

Participating Entities will be disqualified from receiving shared savings payments if they demonstrate repeated or systematic failure to offer medically necessary services or manipulate their member panel, whether or not there is evidence of intentionality. DSS uses a multi-pronged approach to identify and prevent under-service of PCMH+ members. The data points that DSS monitors under this approach include, but are not limited to: PCMH+ member grievances, provider performance on quality measures (particularly preventive care service measures),

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TN # 21-0010

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Connecticut**Pediatric Inpatient Psychiatric Services: Interim Rate-Add-Ons and Change to Medically Necessary Discharge Delay Reimbursement Methodology**

Effective only for dates of service from December 1, 2021 through December 31, 2024, the following payment changes apply to: in-state psychiatric hospital and each of the following in-state hospitals with a pediatric inpatient psychiatric unit: short-term general hospitals, children's short-term general hospitals, and chronic disease hospitals (except that a chronic disease hospital is eligible either if it has a pediatric inpatient psychiatric unit or if it has a dedicated unit for providing specialized behavioral health services to children, including autism spectrum disorder services), plus border hospitals that meet the following: This rate add-on is also potentially available to border hospitals in accordance with the same conditions as in-state hospitals and that also must meet all of the following parameters: licensed short-term general hospital with a pediatric inpatient psychiatric unit or a private psychiatric hospital; located no more than 10 miles from the Connecticut border; and have no fewer than fifty episodes of pediatric inpatient psychiatric services paid by Connecticut Medicaid each year beginning in calendar year 2019 and continuing on an ongoing basis.

Each of the categories of hospitals listed above will be eligible for one or both of the following rate add-ons or change in reimbursement policy, as applicable and as set forth below for applicable pediatric inpatient psychiatric bed days. General hospitals and chronic disease hospitals are reimbursed for pediatric inpatient psychiatric services under the inpatient hospital benefit category set forth in section 1905(a)(1) of the Social Security Act. Psychiatric hospitals are reimbursed for pediatric inpatient psychiatric services under the inpatient psychiatric services for individuals under age 21 set forth in section 1905(a)(16) of the Social Security Act.

1. **Rate Add-On for Increasing Access:** Effective for dates of service from December 1, 2021 through December 31, 2024, each eligible hospital that increases the hospital's daily average number of pediatric inpatient psychiatric beds paid by Connecticut Medicaid for dates of service in each calendar quarter by 10% (rounded to the nearest whole number) or at least 2 beds, whichever is greater, compared to the daily average number of beds paid by Connecticut Medicaid for dates of service in the same calendar quarter in calendar year 2019 and complies with the other requirements set forth below may be eligible for this add-on. If a hospital's approved start date for this rate add-on is not the first day of a calendar quarter, then the calculation of minimum increase in bed days is the daily average number of pediatric inpatient psychiatric beds actually paid by Connecticut Medicaid from the start date through the end of the calendar quarter but is still compared to the average daily average number of beds paid by Connecticut Medicaid for dates of service in the same calendar quarter in calendar year 2019. Notwithstanding the previous two sentences, on a case-by-case basis, each hospital may submit a written request to DSS for an extraordinary circumstances' exception if it was unable to meet such thresholds due to extraordinary circumstance beyond its control. The hospital must also provide the state with real-time bed tracking, conduct post-discharge follow-up with each family, participate in the state's care transition and suicide prevention initiatives, and provide enhanced data reporting to the state. This rate add-on will be paid for all pediatric inpatient psychiatric bed days for each calendar quarter (including medically necessary discharge delay days) in which the hospital meets all of those requirements.

The amount of this rate add-on is as follows:

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Connecticut

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- a. For each eligible in-state non-governmental short-term general hospital that is currently paid in the first or second tier of the three tiered inpatient psychiatric per diem rate system, the add-on will be equivalent to transitioning to the current highest tier which will then increase by 2% each January 1st. This rate, incorporating the add-on, is as follows: calendar year 2021: \$1,170.45; calendar year 2022: \$1,193.86; calendar year 2023: \$1,217.74
 - b. For each eligible border hospital and each eligible in-state children's general hospital and governmental short-term general hospital, the rate add-on will be equivalent to transitioning to the highest rate in the three-tiered system not incorporating any increases due to the 2019 settlement agreement with in-state non-governmental short-term general hospitals. This rate, incorporating the add-on, is \$1,125.00.
 - c. Notwithstanding the above, any hospital that currently receives the highest inpatient psychiatric rate or a chronic disease hospital will receive a 10% rate add-on to the applicable rate.
 - d. For each eligible in-state psychiatric hospital, the rate add-on will be equivalent to transition to the highest rate in the three-tiered system during calendar year 2021. This rate, incorporating the add-on, is \$1,170.45.
2. Rate Add-On for High Acuity: Effective for dates of service from December 1, 2021 through December 31, 2024, each eligible hospital will be paid a 10% rate add-on to the hospital's inpatient psychiatric per diem rate (in addition to the rate add-on under 1. above, if applicable) for the pediatric inpatient psychiatric bed days provided to each child whose behavior demonstrates acuity that requires additional support on the inpatient unit and is sufficiently acute that it interferes with the therapeutic participation or milieu on the inpatient unit of the child or other children based on the condition of the child. To receive this add-on, the state or its agent must approve the hospital's prior authorization request for this add-on which must include the hospital's documentation that the specified bed days meet the requirements of this paragraph.
 3. Modification to Applicability of Medically Necessary Discharge Delay Rates: Effective for dates of service from December 1, 2021 through December 31, 2024, due to current high demand for inpatient services in conjunction with decreased capacity for non-inpatient services, the hospital will be paid the full applicable per diem rate, not the medically necessary discharge delay rate for applicable bed days when the individual no longer needs to remain in the inpatient setting but the state or its agent confirms as part of the authorization or concurrent review process that: the hospital has made and continues to make every attempt to secure the appropriate discharge plan that best meets the individual's needs; the discharge plan is appropriate but cannot be implemented for the applicable dates of service due to lack of availability of community-based services that are appropriate for the individual's discharge plan; and that active treatment is occurring in the hospital based on the individual's needs and meets medical necessity.

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

(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 January 1, 2024 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.

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

(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, 2024. 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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: CONNECTICUT

(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 1, 2024 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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Connecticut

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 January 1, 2024 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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Connecticut

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, 2024 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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Connecticut

(b) Prosthetic devices

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of prosthetic devices. The agency's fee schedule rates were set as of January 1, 2024 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.

(c) Eyeglasses

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of eyeglasses. The agency's fee schedule rates were set as of July 1, 2008 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.

(d) Hearing Aids

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of hearing aids. The agency's fee schedule rates were set as of March 1, 2019 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. The price allowed for hearing aids shall be the actual acquisition cost of the hearing aid(s) to the provider, not to exceed the applicable rates on the Hearing Aid/Prosthetic Eye fee schedule.

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

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 1, 2024 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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Connecticut

- (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 January 1, 2024, 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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Connecticut

(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 January 1, 2024 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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Connecticut

10. 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 January 1, 2024 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 January 1, 2024 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.

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

11. Physical Therapy and Related Services (Physical Therapy, Occupational Therapy, Audiology and Speech and Language Pathology Services).
- a) Physical therapy and related services – Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of physical therapy and related services. The agency’s fee schedule rates were set as of January 1, 2020 and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page, go to “Provider,” then to “Provider Fee Schedule Download,” then select the applicable fee schedule.
 - b) Occupational therapy – Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of occupational therapy services. The agency’s fee schedule rates were set as of January 1, 2020 and are effective for services provided on or after that date. Occupational therapists will be reimbursed according to the fee schedule for physical therapists. All rates are published on the Connecticut Medical Assistance Program website: www.ctdssmap.com. From this web page, go to “Provider,” then to “Provider Fee Schedule Download,” then select the applicable fee schedule.
 - c) Audiology and speech and language pathology services – Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of audiology and speech and language pathology services. The agency’s fee schedule rates were set as of January 1, 2024 and are effective for services provided on or after that date. All rates are published on the Connecticut Medical Assistance Program website: 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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STATE: CONNECTICUT

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 January 1, 2024 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 5:00 PM. Providers that are designated Enhanced Care Clinics and have a valid Letter of Agreement with the Department that holds them accountable to the quality standards and access standards receive the enhanced rate for all routine outpatient services provided. The state monitors the access standards on a routine basis

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TN # 23-0012

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Connecticut**I. Shared Savings Payment Methodology: Individual Savings Pool and Quality Gates for Individual Savings Pool and Challenge Savings Pool****A. Individual Savings Pool Quality Measures and Quality Gates for Individual Savings Pool and Challenge Savings Pool**

The quality measures and quality gates applicable to the payment methodology are described in Attachment 3.1-A and apply to payments made on or after the effective date of the applicable language. Specifically, in order to receive Individual Savings Pool or Challenge Pool shared savings payments, the Participating Entity must meet both of the following quality gates:

(1) Improve on its Total Quality Score. To determine eligibility for this quality gate, each Participating Entity's Individual Savings Pool Quality Measures are averaged for the Prior Year and Performance Year, with each measure receiving equal weighting. Each Participating Entity whose Performance Year average is greater than the Prior Year average becomes eligible to participate in the Challenge Pool.

(2) For each of the potentially preventable hospital admissions (PPA) and the potentially preventable hospital emergency department visits (PPV) measures, each PE must either: (A) be ranked within the top 30% of PEs for that measure in a performance year and/or (B) improve their score on that measure compared to the prior performance year. PEs will meet this quality gate only if they meet at least one of these methods of meeting this updated quality gate for both PPA and PPV.

B. Individual Savings Pool Total Quality Scoring

The Individual Savings Pool will be determined by the Participating Entity's Total Quality Score. The Total Quality Score will be developed based on the Participating Entity's quality scores (Absolute Quality) and improvement on quality scores (Improve Quality). Each quality measure can generate a maximum of two points - one point for the absolute level of quality achieved and one point for the year-over-year improvement in quality.

1. Absolute Quality: For each quality measure, a PCMH+ PE will earn a maximum of one point in accordance with the table below for its ability to reach Absolute Quality targets in the Performance Year. The 2020 Absolute Quality targets will be derived from the 75th percentile of all PCMH+ PE quality scores from 2018. The 2021 targets will be derived from the 75th percentile of all PCMH+ PE quality scores from 2019. These targets will be shared with each PE.

Quality Performance Measured Against Quality Target	Points Awarded
Between 0.00% and 74.99%	0.00
75.00% or greater	1.00

2. Improve Quality: For each quality measure, a PCMH+ PE will earn a maximum of one point in accordance with the table below based on its year-over-year improvement compared to the improvement for all of the PCMH+ Performing Entities. The table for each measure will be derived from all Performing Entities for each Performance Year.

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Sharing Factor: If a Participating Entity has savings following the calculation steps above, these savings will be multiplied by a Sharing Factor of 50%. The resulting amount will form the Entity's Individual Savings Pool.

$$\text{Individual Savings Pool} = \text{Capped MSR Adj. Savings} * 0.50$$

D. Individual Savings Pool Shared Savings Calculation

For each Participating Entity, the Individual Savings Pool Shared Savings payment, if any, is equal to the Individual Savings Pool times the Total Individual Savings Pool Quality Score defined above.

$$\text{Individual Savings Pool Shared Savings} = \text{Individual Savings Pool} * \text{Total Quality Score}$$

II. Shared Savings Payment Methodology: Challenge Pool

A. Challenge Pool Eligibility

To be eligible for a Challenge Pool payment, a Participating Entity must meet the quality gates for the Individual Pool payment described above in this section.

B. Challenge Pool Funding

It is expected that one or more Participating Entities may not receive 100% of their Individual Savings Pool as shared savings payments because of less than perfect scores on the applicable quality measures or because DSS determined that the Participating Entity systematically engaged in under-service for Medicaid members. The amounts not returned will be aggregated to form a target amount for the Challenge Pool. The

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