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, 2025 and apply to 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),

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(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, 2025 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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(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, 2025. 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: 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, 2025, 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. Supplemental Reimbursement for Obstetrical Services

a. Supplemental payments to eligible obstetrical providers shall be paid from a maximum pool of funds of $600,000 per measurement period identified below to obstetrical providers that meet performance measures described below and shall be paid only during each state fiscal year identified below. Performance data will be calculated using paid claims data from Connecticut's Medicaid Management Information System and the online prenatal and postpartum notification forms received from providers without errors. Only episodes of care for which providers use the online obstetric notification forms will be eligible for this supplemental payment.

b. For the performance measurement period of January 1, 2025 through December 31, 2025 and for each state fiscal year thereafter (January 1 through December 31), participating obstetrical providers shall be awarded a performance measure point based on the following criteria.

i. 20 points: First prenatal visit and risk identification within 14 days of a confirmed pregnancy, where at a minimum all of the following have occurred:
    a. Maternal risk screening, including but not limited to:
        a. Blood pressure
        b. Evaluation for co-morbidity, including:
            i. Cardiovascular disease
            ii. Diabetes
            iii. Hypertension
            iv. Clotting disorders
            v. Substance use
    b. Assessment of social determinants of health.

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ii. 60 points: Self-measured blood pressure for members with hypertension in addition to usual perinatal care visits and provider measured blood pressures. To meet this measure, a prescription for a BP monitoring device must be issued.

iii. 60 points: Full term (39 weeks gestation), vaginal delivery.

iv. 50 points: At least one postpartum visit within 21 days of delivery.

v. 30 points: A comprehensive postpartum visit occurring between 22 and 84 days after delivery that addresses all of the following:
   c. Future pregnancy planning
   d. Contraceptive options/choices
   e. Ongoing medical conditions
   f. Behavioral health issues
   g. Substance use/misuse

c. To calculate each obstetrical provider's performance payment, a provider's earned performance measure points during the performance period are summed and divided by the total number of points for all participating obstetrical providers during the performance period. This product calculates a provider's "payout percentage". Each obstetrical provider's performance payment will be the "payout percentage" multiplied by the available supplemental pool. If the participation in this program results in less than 120,000 total performance points among all obstetrical providers participating in this program during a performance measurement period, the maximum dollar value for each performance measure point is five dollars.

d. In order to account for claims submission delay, payment will be made on or after the day that is six months after the performance measurement period.

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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, 2025, 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, including COVID-19 at-home test kits, are reimbursed at Average Wholesale Price (AWP) with no dispensing fee, except for blood glucose testing strips which are reimbursed at WAC (Wholesale Acquisition Cost) with no dispensing fee and alcohol prep pads which are reimbursed at a maximum amount of $6.00 per 100 prep pads with no dispensing fee. COVID-19 vaccines will be reimbursed at AWP + $1.00 with no dispensing fee.

Prescription products and devices provided by pharmacies, including continuous glucose monitoring (CGM) devices, are reimbursed at the device cost specified below plus the professional dispensing fee specified for pharmacies in section 12 of Attachment 4.19-B of the Medicaid State Plan, which is currently $10.75. Reimbursement for the device cost shall be the lowest of: (i) the usual and customary charge to the public or the pharmacy's actual submitted ingredient cost; (ii) the National Average Drug Acquisition Cost (NADAC) established by CMS; (iii) the Affordable Care Act Federal Upper Limit (FUL); or (iv) Wholesale Acquisition Cost (WAC) plus zero (0) percent when no NADAC is available for a specific drug.

(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, 2025, 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.

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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 Performance Years beginning 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 measures, HEDIS® MY 2025, Glycemic Status Assessment for Patients with Diabetes (GSD) and ED visits per 1000 MM, each PE must either: (A) be ranked within the top 30% of PEs for that measure in a performance year and/or (B) improve year-over-year performance on that measure. PEs will meet this quality gate only if they meet at least one of these methods of meeting this updated quality gate for both GSD and ED visits per 1000 MM.

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 Absolute Quality targets for each Performance Year will be derived from the 75th percentile of all PCMH+ PE quality scores from the performance year two years before the current Performance Year.

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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VI. Care Coordination Add-On Payment Methodology (FQHCs Only)

DSS will make Care Coordination Add-On Payments prospectively to Participating Entities that are FQHCs (but not Advanced Networks that include one or more FQHCs) on a monthly basis using a per-member per-month (PMPM) amount for each beneficiary assigned to the FQHC, using the assignment methodology described above. DSS will factor the Care Coordination Add-On Payments in each FQHC's shared savings calculation. For the Performance Year for dates of service for calendar years 2025 and each Performance Year thereafter, except as otherwise provided below, the PMPM payment amount is $4.00.

For the Performance Year for dates of service for calendar year 2020 and all subsequent calendar years, the total pool of funds for making Care Coordination Add-On Payments is $6.36 million. Notwithstanding the PMPM payment amount listed above, if DSS determines that this:

(1) total pool of funds will not be expended by the end of the performance year, DSS shall pay the remaining amount based on each FQHC's proportion of all FQHCs' member months; or

(2) total pool of funds may be reached or exceeded in a calendar month, DSS shall reduce the PMPM amount for that month as necessary in order to remain within the total pool of funds and no PMPM payments will be made for any subsequent months in the performance year.