DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 18-Q: Clarifying Updates to Alternative Benefit Plan (ABP) for the Medicaid Coverage Group for Low-Income Adults Regarding Other Medical Care and Other Types of Remedial Care Recognized Under State Law, Specified by the Secretary, Including Person-Centered Medical Home Plus (PCMH+) and Addition of Dental Coverage Limit

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), which will amend the Alternative Benefit Plan (ABP) at Attachment 3.1-L of the Medicaid State Plan.

The ABP is the benefit package that, effective January 1, 2014, is being provided to the Medicaid low-income adult population under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act (also known as HUSKY D). Pursuant to section 2001 of the Affordable Care Act, effective January 1, 2014, Connecticut expanded Medicaid eligibility to low-income adults with incomes up to and including 133% of the federal poverty level. The expanded coverage group is referred to as Medicaid Coverage for the Lowest-Income Populations.

Changes to Medicaid State Plan

Effective on or after January 1, 2018, SPA 18-Q amends the ABP (Attachment 3.1-L of the Medicaid State Plan) in order to make the following clarifying updates. Specifically, this SPA adds language to confirm that the ABP for HUSKY D Medicaid members continues to reflect the same coverage as described in the underlying State Plan (Attachments 3.1-A and 3.1-B) regarding the benefit category described in section 1905(a)(29) of the Social Security Act, Other Medical Care and Other Types of Remedial Care Recognized Under State Law, Specified by the Secretary. Although the ABP was designed to align completely with the underlying State Plan when it was first established effective January 1, 2014 (and therefore, to include coverage of all categories of service within that benefit category), in addition to the ABP itself indicating that it was fully aligning with the underlying State Plan, specific references to that benefit category was inadvertently omitted from the initial ABP as written and is being added to clarify that those services are also included in the ABP, as was originally intended. The specific services included in that benefit category are all described in detail in Attachments 3.1-A and 3.1-B. Among those services includes the Person-Centered Medical Home Plus (PCMH+) program, which is described in Attachments 3.1-A and 3.1-B within that benefit category and includes primary care case management services as defined in section 1905(t) of the Social Security Act, including the care coordination services described in Attachments 3.1-A and 3.1-B.

In addition to the clarifying updates described immediately above, this SPA also adds the description of the annual financial coverage limitation for dental services provided to adults in the Dental Services (for Adults) within Essential Health Benefit 1 – Ambulatory Patient Services. This limit aligns with SPA 18-H, which establishes the limit in Attachments 3.1-A and 3.1-B of the Medicaid State Plan and provides, effective January 1, 2018, for an annual financial coverage limit for dental services provided to adults age twenty-one and over to a maximum of

$1,000 per calendar year for non-emergency dental services, which can be exceeded with prior authorization based on medical necessity.

This SPA will not make any other changes to the ABP than as described above, which will continue to reflect the same coverage in the ABP for HUSKY D Medicaid members as in the underlying Medicaid State Plan. Accordingly, the ABP will continue to provide full access to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to beneficiaries under age twenty-one. This includes informing them that EPSDT services are available and of the need for age-appropriate immunizations. The ABP also provides or arranges for the provision of screening services for all children and for corrective treatment as determined by child health screenings. These EPSDT services are provided by the DSS fee-for-service provider network. EPSDT clients are also able to receive any additional health care services that are coverable under the Medicaid program and found to be medically necessary to treat, correct or reduce illnesses and conditions discovered regardless of whether the service is covered in Connecticut's Medicaid State Plan.

Likewise, this SPA will not make any changes to cost sharing for the services provided under the ABP. Connecticut does not currently impose cost sharing on Medicaid beneficiaries. Because there are no Medicaid cost sharing requirements for Connecticut beneficiaries, no exemptions are necessary in order to comply with the cost sharing protections for Native Americans found in section 5006(e) of the American Recovery and Reinvestment Act of 2009.

Fiscal Impact

This SPA will not change annual aggregate expenditures.

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: Medical Policy Unit, Department of Social Services, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105 (Phone: 860-424-5067). Please reference "SPA 18-Q: Clarifying Updates to Alternative Benefit Plan (ABP) for the Medicaid Coverage Group for Low-Income Adults".

Anyone may send DSS written comments about this SPA, including comments about access. Written comments must be received by DSS at the above contact information no later than January 25, 2018.

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided: Home Health Services - Nursing Svs

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: See "Other information"

Duration Limit: None

Scope Limit: Not covered: Services for well child care or for prenatal or postpartum care that is not high risk

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

-The cost of services provided by the home health agency may not exceed the cost if the client were in the appropriate institution
-Authorization required for services more than two visits per day and more than two days per week

Benefit Provided: Podiatrist Services

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Dental Services (for Adults)

Source: State Plan 1905(a)

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: See "Other information"

Duration Limit: See "Other information"

Alternative Benefit Plan

Scope Limit:

See "Other information"

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

See Attachment 3.1-A for details. In brief, a summary of limits is as follows: Prior authorization required for non-emergency dental services based on medical necessity; however, prior authorization not required for the following dental services: diagnostic, prevention, basic restoration procedures, nonsurgical extractions.
- One set of bitewing films per year and one oral exam and prophylaxis per year (unless evidence that dental disease is an aggravating factor in person's overall health)
- Fluoride treatment limited to adults who have xerostomia or have undergone head or neck radiation therapy
- One oral examination and one prophylaxis every year (two years for adults living in long-term care facilities);
- Non-emergency services limited to $1,000 per adult beneficiary per calendar year;
- Pre-molar sealants; sealants that fail within 5 years of placement; direct placed restorations that require replacement within 2 years.
- Not covered: Fixed bridges, periodontics (exceptions for gingivoplasty and gingivectomy with prior authorization), implants, transplants, cosmetic dentistry, vestibuloplasty, unilateral removable appliances, partial dentures where there are at least eight teeth in occlusion and no missing anterior teeth, restorative procedures to deciduous teeth nearing exfoliation, resin based composite restorations to the molar teeth and orthodontia

Benefit Provided:

Hospice Care Services

Source:

State Plan 1905(a)

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

See "Other information"

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Authorization required for inpatient hospice care after five days

Add

Other:

Remove

Other 1937 Benefit Provided:
Other Medical Care: Non-Emergency Transportation

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Other:
Brokered transportation

Other 1937 Benefit Provided:
Eyeglasses

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Provider Qualifications:
Medicaid State Plan

Amount Limit:
See "Other"

Duration Limit:
See "Other"

Scope Limit:
None

Other:
One pair per clients twenty-one years of age and older per two year period unless it is medically necessary because of a change in the client's medical condition

Other 1937 Benefit Provided:
FQHCs

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
See "Other" re dental services

Duration Limit:
None

Alternative Benefit Plan

Other:

See Attachment 3.1-K for details regarding this benefit (created through approved SPA 15-012), including service components, limits, and provider information.

Remove

Other 1937 Benefit Provided:

Behavioral Health Homes Pursuant to Section 1945

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Provider Qualifications:

Medicaid State Plan

Amount Limit:

See Attachment 3.1-H

Duration Limit:

None

Scope Limit:

See Attachment 3.1-H

Other:

See Attachment 3.1-H for details regarding this benefit (created through SPA 15-014), including service components, limits, and provider information.

Other 1937 Benefit Provided:

Other Medical Care: Integrated Care Models - PCMH+

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

See Attachment 3.1-A.

Other:

As described in Attachment 3.1-A, the Person-Centered Medical Home Plus (PCMH+) is an integrated care model within the Other Medical Care benefit category in section 1905(a)(29) of the Social Security Act and includes the provision of primary care case management services as defined in section 1905(t) of the Social Security Act.

See Attachment 3.1-A for details regarding this benefit (created through SPA 17-0002), including service components, limits, and provider information.

Add