DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Amendment to the Child Health Plan

SPA CT-18-0011-CHIP: Changes to HUSKY Plus program

The State of Connecticut Department of Social Services (DSS) proposes to submit the following amendment to its Children's Health Insurance (CHIP) Program plan under Title XXI of the Social Security Act to the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services.

Changes to CHIP Plan

Effective on or after March 15, 2018, CT-18-0011-CHIP will amend Appendix 3.1 of the Connecticut Children's Health Insurance program plan for the HUSKY B program. Administrative services for the HUSKY Plus program have transitioned to the same medical administrative service organization that serves as the medical ASO for all other aspects of the HUSKY B program. The ASO conducts prior authorization and case management for all HUSKY Plus services. Providers are reimbursed through the Department's Medicaid Management Information System. All these services have been performed by a different contractor since the inception of the HUSKY Plus program. This transition was intended to streamline the program and achieve greater efficiencies.

Effective March 15, 2018, the Department, will: re-impose limits on select services that existed prior to July 1, 2017, terminate two services that have been unfunded, eliminated coverage for certain services that are not clinically effective, and eliminate coverage for select services because they are covered in the basic HUSKY B benefit package. These changes are necessary to keep HPP expenditures within available appropriations.

Limits have been imposed on the following services:

Rehabilitation and home health services:

- Physical therapy: up to two (2) visits per week with no more than four (4) units per visit per week;
- Occupational therapy: up to one (1) visit per week with no more than four (4) units per visit per week; and
- Speech and language pathology: up to one (1) visit per week and with no more than two (2) units per visit per week.

Medical equipment and supplies:

- Motorized wheelchair: every five years;
- Incontinence supplies for children over the age of 3: up to 180 units per month;
- Hearing aids: for children age 12 and under cost over the $1,000 allowance in a 24 month period and cost covered up to the fee schedule for children 13 years and over;
- Orthotic devices limited to: foot rotation bars and hallux valgus splints.

Coverage of the following services will be eliminated:

- Long term skilled nursing;
- Two non-emergency transportation rides per year.
- Some orthotics: orthopedic shoes, shoe inserts, arch supports, lifts, wedges, heel stabilizers, counters and pads, foot positioning devices and inserts.

The following services are being eliminated from HPP, as they are covered in HUSKY B:

- Over the counter medications including nutritional formulas
- Ten hours of home health aide per week
- Adaptive seating
- Nutritional consultation
- Dental care for mal-occlusive disorders.

Appeals for goods or therapy services exceeding the benefit limits will not be considered because the program does not allow for expenses beyond an annual budgeted amount.

Fiscal Impact

Based on available information, DSS estimates that this amendment will have no fiscal impact in FFY 2018 and FFY 2019. All HPP services are pre-authorized and reimbursed at Medicaid rates.

Obtaining SPA Language and Submitting Comments

This CHIP plan amendment is posted on the DSS web site at this 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 "CHIP/HUSKY B Plan Amendments". To request a copy of the SPA from DSS or to send comments about the SPA, please email: laura-victoria.barrera@ct.gov write to: HPP/Integrated Care Unit, Department of Social Services, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105 (Phone: 860-424-4892). Please reference "CT_18-0011-CHIP: Changes to HUSKY Plus program".

Anyone may send DSS written comments about this SPA. Written comments must be received by DSS at the above contact information no later than March 27, 2018.

APPENDIX 3.1
HUSKY PLUS Program
SUPPLEMENTAL INSURANCE COVERAGE

I. HUSKY Plus Program Overview

The HUSKY Plus Program provides supplemental coverage to children and youth with intensive physical health needs who are eligible for and enrolled in HUSKY B. HPP is a supplemental program, administered within available appropriations according to state law.

There are no co-pays, deductibles or additional premiums for HPP services. HPP services supplement HUSKY B services once a child has exhausted an applicable benefit limit under HUSKY B. HPP will always be the payer of last resort.

Children who are eligible under HPP are **dually eligible.** That is, children who are determined to be eligible under HPP will continue to receive HUSKY B covered services so the child may obtain services to the fullest extent possible in the least restrictive setting.

II. HUSKY Plus for Children and Youth with Intensive Physical Needs

Program Administration

The Department of Social Services (DSS) administers the HPP program. On July 1, 2017, DSS transitioned the day-to-day administration of the program to DSS' Medical Administrative Services Organization (ASO) for Medicaid and CHIP. The medical ASO is responsible for direct evaluation of member's needs and provision of intensive care management as well as arranging and pre-authorizing services through the Connecticut Medical Assistance (CMAP) network of providers and vendors.

The DSS claims payment/ Medicaid Medical Information System (MMIS) contractor reimburses providers.

Eligibility

Children enrolled in HUSKY B who have intensive physical health needs that cannot be met within the HUSKY B benefit package are eligible for supplemental services under the HPP program.

> The age of eligibility is birth to 18 years. Eligibility for HPP ends at age 19, when eligibility for HUSKY B ends.

Referral to HPP

Children who may benefit from HPP will be identified by their parents, their primary care provider, another HUSKY B provider or the medical ASO. Providers may request services in writing, electronically or by telephone. The authorization process for HPP services is coordinated by the medical ASO.

Covered Services That Require Prior Authorization

All HPP services require prior-authorization. HPP services include the following when not covered or are exhausted under the HUSKY B benefit package:

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- Medical or surgical supplies: Limited to combined 180 diapers and pull ups, and up to 180 combined disposable liners, shield/under and pads for members age three (3) or over.

- Long term rehabilitation or long term physical therapy, subject to the following:

  - Physical therapy is limited to two (2) visits per week with no more than four (4) units per visit;

  - Occupational therapy is limited to one (1) visit per week with no more than four (4) units per visit;

  - Speech and language therapy is limited to one (1) visit per week and no more than two units (2) per visit.

- Durable medical equipment, exclusive of the basic HUSKY B benefits, including, but not limited to, items that assist in the activities of daily living;

  - One new motorized wheelchair limited to one every five years. Repairs and modifications to motorized wheelchair, other than seating, will be covered up to two times per year.

  - Hearing aids for children:

    - Age 12 or under cost of hearing aid(s) over $1,000 in a 24 month period.
    - Age 13 or over: hearing aids, dispensing fee, ear molds, batteries and repairs (outside of warranty) in a 24 month period.

  - Orthotic devices: Limited to two (2) pairs each, per year of: foot rotation bars and hallux valgus splints. Includes all delivery fees, fittings and adjustments.

Services re-aligned as part of HUSKY B coverage:

- Over the counter medications, if medically necessary and related to the condition that qualifies the child for the program.
- A home health aide provided by a licensed home health agency to assist the family to provide personal care to the child up to ten hours per week;
- Specialized adaptive seating, limited to one evaluation, fabrication and completion per year. Adjustments to adaptive seating are limited to two times per year One visit per day for evaluation, treatment and education;
- Nutrition consultation and treatment by registered dieticians consistent with the care plan; nutritional formulas and rehabilitative sustenance of a type or amount not usually required by children, if prescribed by an authorized professional within acceptable standards of the American Dietetic Association;
- Dental care and orthodontia for children who have malocclusive disorders or periodontal disease resulting from their underlying qualifying condition or related treatment;

Services to be terminated:

- Long term skilled nursing shall be provided by a licensed home health agency, subject to the following: one visit per day for evaluation and education; and a re-evaluation shall be performed after thirty days.
- Two round trip rides per year to any health care appointment by ambulance, chair-van or other licensed medical transportation service; and ambulance travel requires documentation that it is the safest and most appropriate means of transportation for the child.
- Orthotic: orthopedic shoes, shoe inserts, arch supports, lifts, wedges, heel stabilizers, counters and pads and foot positioning devices.

This list may be revised from time to time as recommended and approved by DSS.

Service Utilization Management

HPP services will be reimbursed at Medicaid rates and will use the Medicaid definition of medical necessity or medically necessary.

All services will be subject to prior authorization by the medical ASO to determine if they are medically necessary. The limitations on HPP services may not be overridden on the basis of medical necessity if the benefit is not covered or exhausted because HPP is limited to an annual, budgeted dollar amount. Therefore, appeals for goods and services exceeding the benefits limits will not be considered. The Department may ask the medical ASO to develop a priority list for the authorization of supplemental services in the event that the funds are not sufficient to meet the needs of children eligible for HPP. Such priority list shall include several factors including HUSKY B Band level and diagnostic severity.

Coordination of HPP Services with HUSKY B

In order to ensure HPP will be the documented payer of last resort, the medical ASO shall ensure that services available through the HUSKY B basic benefit package, are exhausted before approving HPP services.

The ASO Prior Authorization Care Manager shall coordinate to ensure that both HUSKY B and HPP services are coordinated.

Program Quality

DSS will review HPP as part of the larger HUSKY Health program. DSS reviews the medical ASO quarterly program and financial reports. Based on the DSS review, recommendations for program quality improvement may be identified and corrective action plans and quality improvement projects will be initiated by the medical ASO in conjunction with DSS.

Grievance and Appeals Process

HPP uses the same grievance and appeal process as HUSKY B. In accordance with 42 CFR 457 sections 1120 – 115 inclusive, an HPP member has the right to request an administrative review conducted by DSS regarding a decision made on his or her HPP prior authorization request. Parents and providers will be encouraged and supported in the filing of appeals without fear of compromised service. A copy of the appeals

procedure, written in a manner easily understood by the lay public, will be distributed to every family at the time of a medical necessity denial of HPP services.

The state ensures that all members receive timely written notice of any determinations required to be subject to review, as outlined below. Written notices at each level include the reasons for the determination, an explanation of applicable rights to review of that determination, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which enrollment may continue pending review.

The following decisions, exclusive of paragraph below, can be appealed through the appeals process:

1. Denial of HPP program eligibility;

2. Failure to make a determination of eligibility not more than twenty-one days after the date of referral to HPP;

3. Opportunity for external review of:
   - Delay, denial, reduction suspension or termination of health services, in whole or in part including determination about the type or level of services; and
   - Failure to approve services in a timely manner.

HPP members may appeal the medical necessity denial of HPP covered services but not the limits on those services. The limitations on the HPP services, as listed in the Covered Services section, cannot be appealed.

While an appeal is the enrollee will remain eligible for HPP and goods and/or services will be continued until the appeal is concluded. The appeal process will consist of two levels: the first to the medical ASO, the second to the DSS.

Whenever a decision is made regarding a member's HPP eligibility, or authorization for goods or services, the medical ASO will issue a denial letter to the member or parent/guardian, describing the decision. Denial letters will also include a one page Appeal Form and a copy of the Appeals Procedure Summary. To begin the appeals process, the member or parent/guardian should complete the Appeal Form. The Appeal Form should be mailed or delivered to the medical ASO within 45 days of the date of the denial letter.

Level One Appeal:

The medical ASO will send a letter that acknowledges receipt of the Appeal Form to the member or parent. The letter will identify an Appeals Coordinator at the medical ASO. The Appeals Coordinator will track the appeal, act as the contact person for questions and updates, and will process the appeal within ten days. If the appeal is resolved to the satisfaction of the member or parent/guardian, a letter will be sent describing the resolution, an authorization will be entered and there will be no further action. If the appeal cannot be resolved at this level, a Level Two appeal will be available.

Level Two Appeal:

A member or parent/guardian who has exhausted the Level One appeal mechanisms of the HPP program and who is not satisfied with the outcome of the decision by the medical ASO may request an administrative review/Level Two appeal. The Level Two

appeal process is conducted by DSS. No one directly involved in the decision being appealed will be involved in the Level Two appeal review process.

The DSS administrative reviewer shall evaluate all factors related to the decision that was made and shall offer the member or parent/guardian the opportunity to have a personal conference with the administrative reviewer as part of the review process. Personal conferences may be conducted in person, by telephone or video-conferencing, at the option of the department.

A letter will be sent to the member or parent/guardian that gives the time and date of the Level Two appeal meeting. If a member or parent/guardian or their representative requests an administrative review/Level Two appeal, in accordance with section 17b-304-6 of the Regulations of the Connecticut State Agencies, and as provided for in subsection (d) of this section, the DSS program representative and the medical ASO representative shall submit any material requested by the DSS concerning the appeal, including, but not limited to:

- all records of the Level One appeal; and
- all actions taken to resolve the appeal by such program.

The DSS HPP program representative or the agent for the HPP program, at the discretion of the DSS, shall attend any personal conference scheduled in accordance with section 17b-304-6 of the Regulations of the Connecticut State Agencies.

The DSS' administrative reviewer shall render a decision in writing to the member or parent/guardian not later than fifteen calendar days following the date of receipt of the request for the administrative review.

Expedited Appeal:

Pursuant to 42 CFR § 457.1160, the appeal process for HPP must allow for expedited review. A member or parent/guardian may request an expedited review. DSS shall determine not later than one business day after receipt of the request, whether to expedite the review or whether to perform the review within the standard time frames. The review may be expedited if DSS determines that the standard time frame could seriously jeopardize life, health or ability to maintain, attain or regain maximum function of the member. If the request for an expedited appeal is approved, DSS shall issue a decision within seventy-two hours of the approval. The time frame may be extended up to fourteen calendar days upon request from the member or parent/guardian.