State of Connecticut – Department of Social Services
Access Monitoring Review Plan for Connecticut's Medicaid Program

APPENDIX 1

Access Analyses for Payment Reduction Medicaid State Plan Amendments

Submitted September 30, 2016

As required by federal regulations at 42 C.F.R. §§ 447.203(b)(5)(ii)(F), 447.203(b)(6), 447.204(a), and 447.204(b), this Appendix 1 to the Access Monitoring Review Plan for Connecticut's Medicaid Program includes the Access Analyses for Medicaid State Plan Amendments (SPAs) submitted in the calendar quarter ending September 30, 2016 that reduce rates or restructure provider payments in circumstances when the changes could result in diminished access, as follows:

- SPA 16-0023 – Home Health Medication Administration Reimbursement Reduction
- SPAs 16-0028 and 16-0030 – Dental Services Reimbursement Reductions
- SPA 16-0029 – Autism Spectrum Disorder Treatment Services Reimbursement

Each of these Access Analyses is also included as part of each SPA's submission package that the state is submitting to CMS simultaneously with this Appendix.

CT SPA 16-023 / HOME HEALTH MEDICATION ADMINISTRATION REDUCTION

ACCESS ANALYSIS

Submitted September 30, 2016

Medicaid State Plan Amendment (SPA) 16-023 proposes to reduce the rate for medication administration (billed with procedure codes T1502 and T1503) by 15% when provided by a registered nurse as part of a licensed home health agency. Specifically, this SPA reduces the rate for procedure codes T1502 (administration of oral, intramuscular and/or subcutaneous medication by health care agency/professional, per visit) and T1503 (administration of medication, other than oral and/or injectable, by health care agency/professional, per visit) from $61.13 to $51.96 per visit.

In addition to medication administration performed by a licensed nurse, the state also reimburses home health agencies for three additional methods for performing medication administration services. Specifically, Medicaid also reimburses for: (1) nurse delegation to a certified home health aide to administer medication (approved in SPA 14-011, effective January 1, 2014); (2) electronic medication dispensing machines ("med boxes") (approved in SPA 13-039, effective December 1, 2013); and (3) medication prompting provided by a home health aide (approved in SPA 15-049, effective October 1, 2015). When clinically appropriate for an individual, each of these three alternative means of providing medication administration services reflects a person-centered, recovery-oriented approach. In addition to promoting individuals' choices and independence, each of these three services is also more cost effective than medication administration provided by a licensed nurse.

This SPA is necessary—and complies with section 1902(a)(30)(A) of the Social Security Act for multiple reasons.

First, reducing the difference in rates between nurse-provided medication administration and alternative means of providing this service [nurse delegation of medication administration to certified home health aides, use of medication administration devices ("med boxes"), and medication administration prompting by home health aides] incentivizes increased use of those alternatives. As compared to the traditional medical model of home health supports performed by a licensed nurse, the more flexible and self-directed alternative means of medication administration maximizes choice and independence for individuals living in the community. This approach is consistent with the Department's commitment to person-centeredness and a recovery-oriented approach. All three alternative means of providing medication administration were developed in close collaboration with home health agencies and other stakeholders. However, despite active promotion and extensive stakeholder engagement by the Department

and its sister state agency, the Department of Public Health, to address scope of practice and other operational concerns, utilization of those alternatives has been very low.

Second, reducing home health medication administration expenditures is a key means of enabling individuals to transition to the community from institutional settings using Money Follows the Person (MFP) supports. Transitions are a key strategy in the Governor-led Rebalancing Plan. Data collected over the entire tenure of MFP in Connecticut has illustrated that the high cost of medication administration has been a specific barrier to, and in some cases entirely impeded, transition. Often times, the use of agency-based nurses to provide this service would represent such a high proportion of an individual's plan of care that the cost cap for involved waivers would not be sufficient to meet the entirety of an individual's home and community-based service needs. By reducing those expenditures—both directly through the rate reduction and indirectly by further encouraging the use of less costly methods of providing medication administration services—this SPA will help reduce barriers for individuals to return home.

Third, this reduction is necessary to reimburse more efficiently for medication administration services. Specifically, as described above, nurse-provided medication administration should only be provided when medically necessary and when the alternative means of providing these services is not clinically appropriate for an individual. Reducing the cost of nurse-provided medication administration increases the incentives for home health agencies to use the alternative means of providing this service whenever it is clinically appropriate to do so.

As described below, in accordance with 42 C.F.R. § 447.204(a), prior to the submission of this SPA, the state considered the data collected and analysis performed for this service and the input from beneficiaries, providers, and other affected stakeholders regarding the potential impact of this SPA on access to this service. Further, in accordance with 42 C.F.R. § 447.203(b)(6), the analysis below includes an access review that is being attached to the state's Access Monitoring Review Plan and monitoring procedures to ensure ongoing monitoring of access to this service. As explained below, this analysis demonstrates that there remains sufficient access to this service.

Measures and Analyses

The following measures demonstrate that there is sufficient access to home health care providers and specifically, to medication administration provided by home health providers using licensed nurses, which is the service affected by this SPA. The state has determined that this SPA complies with access requirements based on an analysis of the following measures: (1) total number of Medicaid beneficiaries; (2) number of enrolled home health providers; (3) utilization

of medication administration by home health providers; and (4) the availability of alternative services described above (nurse delegation, med boxes, and med admin prompting).

Figure 1 shows the total number of Medicaid beneficiaries by eligibility type enrolled for calendar years (CY) 2013 through 2015. Based on this data, HUSKY A and D enrollment increased in the three-year span from CY 2013 through 2015. HUSKY D experienced an 85.5% increase in enrollment, and membership in HUSKY A increased by 12.0% over the three year period. These increases were largely due to the implementation of the Medicaid expansion under Section 2001 of the Affordable Care Act effective on January 1, 2014. During that same period, enrollment in HUSKY C, Connecticut's program for individuals who are aged 65 or older, are blind or have a disability, remained relatively stable with a slight decrease (4.8%) over time.

Figure 1. Total number of Medicaid Beneficiaries by Eligibility Type CY 2013 - 2015

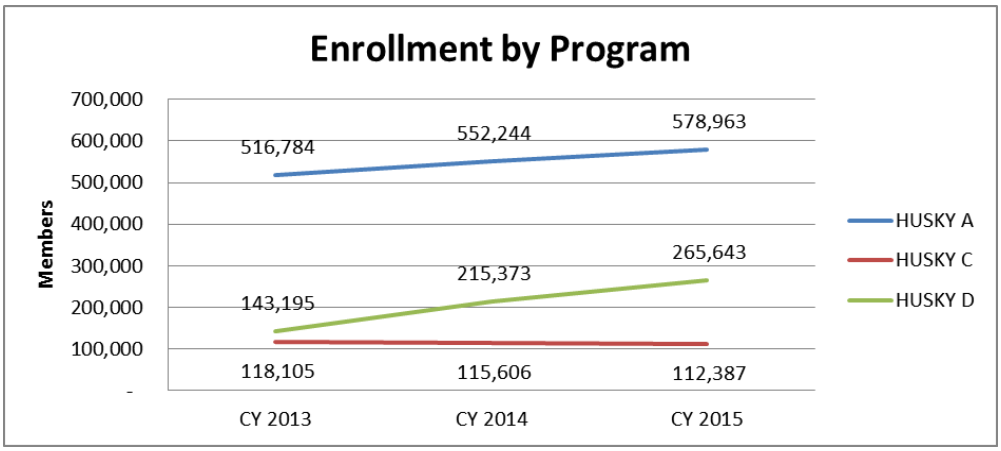
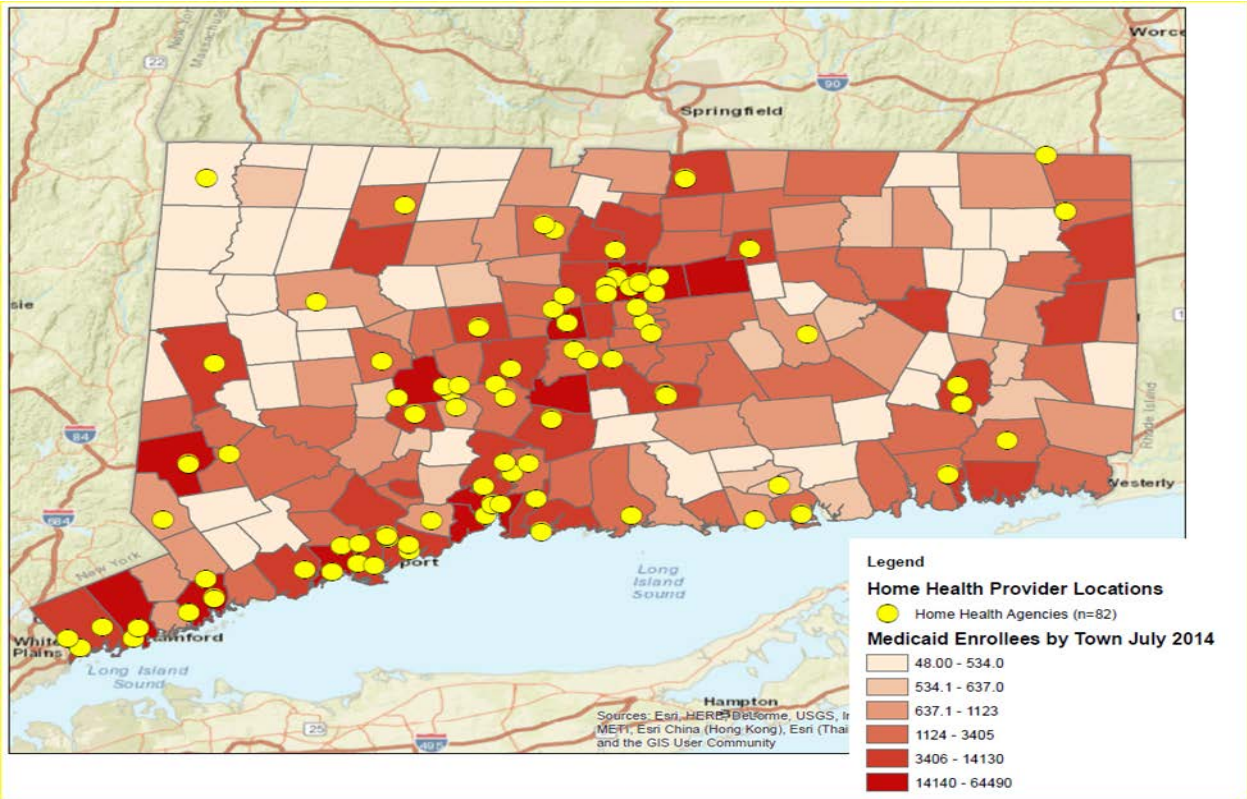


Figure 2 shows that there are 82 home health providers enrolled in CMAP and serving CMAP members. The yellow dots identify the location of the enrolled home health provider address associated with a billing identification number. There is far more comprehensive coverage of the state than the figure shows, however, because it does not show (1) the service locations for each enrolled home health provider (as many service a large area within the State), or (2) the number of individuals contracted to work with each home health provider. Submission of the service locations and individuals contracted to work for each home health provider would be challenging to track and update and so it is not required as part of the enrollment process with CMAP.

Figure 2: CT Home Health Agencies



As shown by this data, there are multiple home health agencies enrolled in Connecticut's Medicaid program and providing services throughout all areas of the state. Accordingly, based on this data, the Department determines that there is a robust provider network of home health agencies.

Utilization

Figures 3 and 4 show the utilization of the codes affected by this SPA (T1502 and T1503) for calendar year 2015 by county and adult (21 years and older) versus children (0-20 years). Calendar 2015 data is used because there has been sufficient claims run-out for that data (*i.e.*, there has been sufficient time to account for the time delay from the date of service until claims are submitted, processed, and paid).

Figure 3: Utilization of Medication Administration Codes T1502 and T1503 By County (Beneficiaries Age 21 and older) – CY 2015

Recipient County	Undup Recipient ID	Unduplicated ICN Count	Number of Billing Providers	Units of Service	Procedure Description
001 - Fairfield	1568	45952	31	350,367	T1502
001 - Fairfield	19	36	3	101	T1503
003 - Hartford	2818	69199	37	595,222	T1502
003 - Hartford	10	17	3	27	T1503
005 - Litchfield	291	7005	20	44,819	T1502
005 - Litchfield	3	3	2	4	T1503
007 - Middlesex	304	6866	20	66,376	T1502
009 - New Haven	3587	96193	40	780,667	T1502
009 - New Haven	13	51	5	131	T1503
011 - New London	371	11567	14	88,756	T1502
011 - New London	1	1	1	1	T1503
013 - Tolland	146	2422	17	25,897	T1502
015 - Windham	195	2815	8	37,529	T1502
015 - Windham	6	17	3	652	T1503

Figure 4: Utilization of Medication Administration Codes T1502 and T1503 By County (Beneficiaries Ages 0 -20 Years) – CY 2015

Recipient County	Undup Recipient ID	Unduplicated ICN Count	Number of Billing Providers	Units of Service	Procedure Description
001 - Fairfield	83	1788	11	12,963	T1502
003 - Hartford	76	776	12	7,835	T1502
005 - Litchfield	10	169	4	1,447	T1502
007 - Middlesex	14	242	4	2,593	T1502
009 - New Haven	79	1085	14	11,245	T1502
011 - New London	4	47	3	230	T1502
013 - Tolland	6	64	4	471	T1502
015 - Windham	3	8	3	37	T1502

*T1502 - Administration of oral, intramuscular and/or subcutaneous medication by health care agency/professional, per visit

*T1503 - Administration of medication, other than oral and/or injectable, by a health care agency/professional, per visit

The utilization data above demonstrates that there are multiple home health agencies providing a substantial volume of service throughout the state.

Rate Comparison

In contrast to the Medicare program, which reimburses for home health services through a per episode payment rate, CMAP reimburses for home health services for as long as such services are medically necessary. Thus, unlike for Medicare, a substantial number of individuals receive home health services through CMAP for many years. Medication administration is reimbursed on a per encounter basis under CMAP and a flat fee is reimbursed each time a home health provider goes to an individual's home to administer medication (i.e., for beneficiaries requiring medication administration two times per day, the home health provider is reimbursed the medication administration rate for each encounter with the beneficiary). Additionally, other state

Medicaid programs reimburse for home health services through methodologies different than Connecticut, including episode payments similar to Medicare. For these purposes, a rate comparison is not possible.

Public Process

For several years, the Department, its sister state agency, the Department of Public Health, and other state agencies have actively engaged in dialogue with home health agencies to improve the efficiency and person-centeredness of medication administration services. As a direct outgrowth of those discussions, in 2012, state statute was amended (effective January 1, 2013) to change the scope of practice requirements for nurses to enable nurses to delegate medication administration to certified home health aides. As noted above, the Department implemented Medicaid reimbursement for that service in SPA 14-011. The Department also actively engaged with providers in establishing reimbursement for med boxes, through SPA 13-039. More recently, at the request of home health agency providers, the Department also added reimbursement for medication administration prompting by home health aides, through SPA 15-049, effective October 1, 2015.

The purpose of these discussions was to enable the Department and providers to reach mutually acceptable methods of improving the quality, efficiency, and access of medication administration services. The Department understood the providers' active participation in those discussions to represent a commitment to providers steadily increasing the use of those alternative means of providing medication administration whenever clinically appropriate for a Medicaid beneficiary. Unfortunately, to date, the utilization of those alternative means of providing medication administration services remains minimal compared to the utilization of medication administration services provided by nurses.

In addition to the discussions described above, providers were first notified about the likelihood of this SPA being implemented through the state budget process in the 2015 state legislative session. Specifically, in June 2015, the General Assembly adopted a state budget for the state fiscal year (SFY) 2016-2017 biennium that assumed a reduction in medication administration expenditures of $20 million annually (state and federal share combined). Directly related to that budget reduction, which was actively discussed with home health providers, section 387 of Public Act 15-5, June special session, amended Conn. Gen. Stat. § 17b-242(c) to give the Department specific authority to implement a reduction in medication administration rates. These revisions to the state budget and to state statute were widely known and discussed with home health agencies.

In addition to the above discussions, prior to implementing the medication administration reduction, the Department hosted a state-wide home health provider meeting on February 29,

2016. Several sister state agencies joined DSS to discuss the medication administration expectation with the home health agencies. At this meeting, representatives from over 35 home health agencies were in attendance.

On May 31, 2016, the Department posted and sent a provider bulletin to all home health providers advising them of the medication administration rate reduction proposed by this SPA. The Department also published the public notice for this SPA in the Connecticut Law Journal (the state's official register) on May 31, 2016. Both the provider bulletin and the public notice described the reduction and also referenced the federal access regulations.

The Department has continued to engage in dialogue with home health agency providers, both formally and informally. For example, home health agency providers organized a public legislative forum on June 16, 2016, at which the Department participated and engaged in direct dialogue with home health agencies and other stakeholders. In addition, multiple meetings of the legislatively-constituted Council on Medical Assistance Program Oversight (MAPOC) included public discussion about this SPA. MAPOC membership includes a representative from the Connecticut Association for Health Care at Home, which is a trade association for home health agencies in Connecticut. Other discussions involved smaller conversations between the Department and providers and other stakeholders.

In addition to providers expressing their opinions as to why they believed that a rate reduction was not necessary, the provider association referenced above and some individual providers also proposed a potential alternative means to achieve some of the cost savings projected by this SPA. That proposal sought to reduce the second visit in a day for a Medicaid member by 50% but also to maintain the existing rate for all individuals receiving only one visit per day. While the Department appreciated providers' willingness to work with the Department to improve the cost efficiency of the program, that alternative proposal would not achieve the goals described at the beginning of this analysis. Specifically, it would not change the overall incentive to continue providing medication administration through nurses, rather than shifting, as clinically appropriate, to use of the more person-centered and less costly alternatives described above.

In addition to the comments from providers and other stakeholders in the conversations described above, the State also received multiple written public comments from home health providers and other stakeholders about this SPA's rate reduction.

The Department has carefully considered all of the input provided by beneficiaries, providers, and other stakeholders in deciding to implement and submit this SPA. While the Department understands the concerns that have been raised, the Department has determined that this SPA is necessary for the reasons described at the beginning of this analysis. In addition, as explained

throughout this analysis, the Department has determined that there will continue to be sufficient access to this service.

In addition to the formal SPA public comment process, beneficiaries, providers, and the public may also continue to contact the Department with access concerns, as well as contact the medical or behavioral health administrative services organizations (ASOs) or the Department's provider relations and MMIS contractor/fiscal intermediary to raise access issues. The ASOs track and resolve all access-related complaints. The tracking is specific to the specialty or type of service that is being requested. A beneficiary may also contact the Department's staff directly, who would either refer the beneficiary to the ASO or work directly with the beneficiary to address any potential access issues.

Monitoring Procedures and Potential Modifications / Corrective Action

The State's general monitoring process includes monitoring of access for all types of care: (1) through its medical ASO Member/Provider Call Center Tracking Report, (2) through the Mystery Shopper Survey, and (3) GEO Access Report, which runs at least annually or more as needed and tracks providers based on the beneficiaries' zip codes and flags areas where providers are outside of the designated 15 mile radius. If access issues are raised, the Department also assigns staff to help the ASO address and resolve the access issue. Providers also regularly contact the Department directly with concerns regarding fees. If the Department receives feedback, it is promptly reviewed to determine appropriate measures to ensure continued access to care for the specific services. In addition to these established monitoring procedures, the State is implementing monitoring procedures specific to ensuring compliance with 42 C.F.R. § 447.203(6)(ii). These procedures will include an annual review of unduplicated recipients of medication administration provided by home health agencies, utilization of medication administration services and the number of enrolled home health agencies. This data will be compared with baseline data pulled for calendar year 2015 to analyze increases or decreases in the number of beneficiaries receiving services, the overall utilization of services and to assess for changes in the number of enrolled home health providers. Based on the results of the analyses, in addition to assessing the uptake in utilization of alternative services (nurse delegation, med boxes and medication prompting) and assessment of ongoing beneficiary and provider feedback (consistent with § 447.203(b)(7)), the State will determine whether or not the proposed rate reduction is demonstrating a negative impact on the access to medication administration services provided by home health providers. If the State determines that the proposed SPA is resulting in a deficiency in access to care or inadequate access, the State will develop and submit a corrective action plan with specific steps and timelines to remedy the deficiencies.

Conclusion

As described above, the Department has carefully considered all of the relevant data regarding utilization, provider network, rate comparison, and other relevant factors in determining to submit this SPA. Based on that analysis, the Department has also determined that there remains sufficient access to this service and that such access is expected to continue after implementation of this SPA.

CT SPAs 16-0028 and 16-0030 / Dental Reimbursement Reductions

ACCESS ANALYSIS

Submitted September 30, 2016

Medicaid State Plan Amendments (SPAs) 16-0028 and 16-0030 propose to reduce the rates for dental services provided to children. The initial proposal (then described as SPA 16-022) was to reduce rates for dental services provided to children for all dental codes effective July 1, 2016 by 5%. However, in response to provider and stakeholder input, the state made changes to that initial proposal. Ultimately, the 5% reduction was never implemented. Instead, a much smaller reduction of 2% was implemented effective September 1, 2016 pursuant to SPA 16-0030 (formerly designated as SPA 16-022, except SPA 16-0030 does not change the rates for the codes affected by SPA 16-0028). In addition, SPA 16-0028 proposes to reduce the rates for several dental codes effective August 1, 2016 to specified amounts, including D2930 (Prefab Stainless Steel Crown (Primary)), D2931 (Prefab Stainless Steel Crown Permanent), D2934 (Aesthetic Coated Stainless Steel Crown), and D8670 (Periodic Orthodontic Treatment). SPA 16-0028 also changes the coverage requirements to tighten the soft limits on sealants and direct placed restorations. These changes were implemented in order to achieve the savings assumed in the State Fiscal Year 2017 state budget that was approved by the Connecticut General Assembly in Public Act 16-1 of the May 2016 Special Session.

As described below, in accordance with 42 C.F.R. § 447.204(a), prior to the submission of these two SPAs, the state considered the data collected and analysis performed for this service and the input from beneficiaries, providers, and other affected stakeholders regarding the potential impact of these two SPAs on access to this service. Further, in accordance with 42 C.F.R. § 447.203(b)(6), the analysis below includes an access review that is being attached to the state's Access Monitoring Review Plan and monitoring procedures to ensure ongoing monitoring of access to this service. As explained below, this analysis demonstrates that there remains sufficient access to the services affected by these two SPAs.

Measures and Analyses

The State looked at several measures to demonstrate that there is sufficient access to dental providers and that the proposed rate reductions would not negatively impact access to dental services. The state has determined that each of these two SPAs comply with access requirements based on an analysis of the following measures: (1) total number of Medicaid beneficiaries; (2) number of enrolled dental providers; and (3) utilization of dental services. The State does not anticipate a negative impact on access to care for dental services proposed by SPA 16-0028 or SPA 16-0030.

Figure 1 shows the total number of Medicaid beneficiaries by eligibility type enrolled for calendar years (CY) 2013 through 2015. Based on this data, HUSKY A and D enrollment increased in the three-year span from CY 2013 through 2015. HUSKY D experienced an 85.5% increase in enrollment, and membership in HUSKY A increased by 12.0% over the three year period. These increases were largely due to the implementation of the Medicaid expansion under Section 2001 of the Affordable Care Act effective on January 1, 2014. During that same period, enrollment in HUSKY C, Connecticut's program for individuals who are aged 65 or older, are blind or have a disability, remained relatively stable with a slight decrease (4.8%) over time.

Figure 1. Total number of Medicaid Beneficiaries by Eligibility Type CY 2013 – 2015

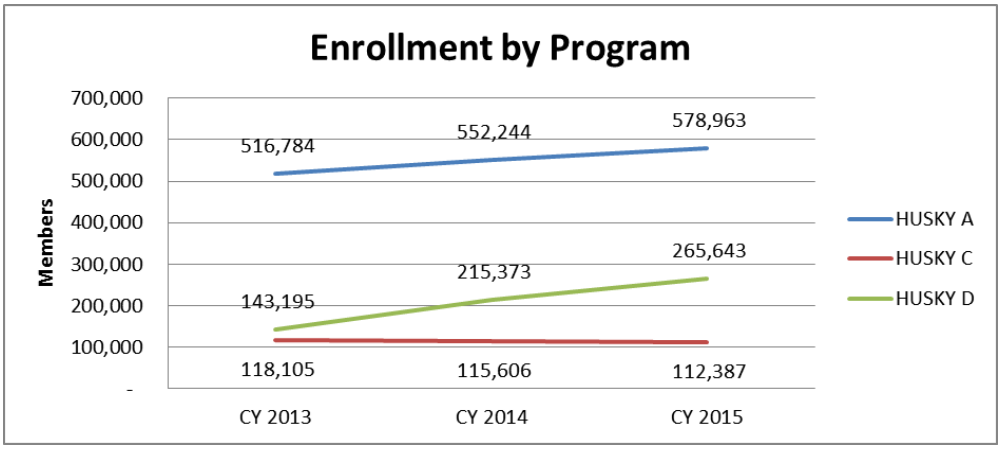


Table 1 shows the count of dental performing providers in the independent dental office setting who were enrolled under CT Medicaid by county for CY 2015. Based on the numbers below, the counties with the greatest CT Medicaid populations (Fairfield, Hartford and New Haven) also have the greatest number of independent dental practitioners enrolled. Although the remaining counties have significantly fewer independent dental practitioners, the following needs to be taken into consideration: (1) these counties have significantly fewer enrolled CT Medicaid beneficiaries; (2) many of the counties are deemed underserved areas in general and not just specific to CT Medicaid enrollment; and (3) beneficiaries in these areas still have access to at least two primary care dentists within a 15-mile radius (and an overall ratio of one primary care dentist for every 2,400 Medicaid beneficiaries). In addition to the independent dental practitioners enrolled in each county, there are also clinic-based providers (federally qualified health centers and hospital-based dental clinics) that also provide access to dental services for Medicaid beneficiaries.

Table 1: Counts of CT Medicaid Independent Dental Practitioners, Calendar Year 2015

Independent Dental Practitioners	**Statewide Performing Provider Count**
Provider County Description	**CY 2015**
Fairfield	306
Hartford	396
Litchfield	41
Middlesex	47
New Haven	345
New London	59
Tolland	30
Windham	21

Utilization

Table 2 outlines the utilization of dental services by county and categorized by adult and pediatric populations. This data was extracted based on dates of service paid in calendar year 2015 and will serve as the baseline data source for future analysis of dental service utilization in order to determine if the rate reductions proposed under these two SPAs have negatively impacted access to dental services. Calendar year 2015 data is used because there has been sufficient claims run-out for that data (*i.e.*, there has been sufficient time to account for the time delay from the date of service until claims are submitted, processed, and paid).

Table 2: Utilization of Dental Services by County and Age CY 2015

County	Count of Services	Age
FAIRFIELD	540,791	C
FAIRFIELD	305,575	A
HARTFORD	484,316	C
HARTFORD	337,089	A
LITCHFIELD	70,459	C
LITCHFIELD	52,229	A
NEW HAVEN	362,130	C
NEW HAVEN	519,007	A
NEW LONDON	95,818	C
NEW LONDON	53,983	A
TOLLAND	40,936	C
TOLLAND	29,322	A
WINDHAM	32,106	C
WINDHAM	55,471	A

C = child beneficiaries (ages 0-20 years)
A = adult beneficiaries (age 21 and older)

Rate Comparison

Since Medicare does not pay for dental services, the rate comparison focuses only on reimbursement under New York's and Massachusetts' Medicaid programs. Additionally, given the vast nature of the dental fee schedule, the following comparison focuses on dental primary care services. Connecticut's dental fee schedule reimburses for services rendered to adult members at 52% of the rate reimbursed for services rendered to the pediatric population. On the CT Dental Fee Schedule, the pediatric population is defined as members under the age of 21 years.

Like Connecticut, Massachusetts' Medicaid program reimburses separately for adults and children (Allowed Fee for adults and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for children under age 21). The rate analysis between Connecticut and Massachusetts compares adult-to-adult and child-to-child rate types. New York pays a single dental service fee that is applicable to both children and adults. For direct rate analysis purposes, Connecticut's rate for children was compared to New York's single rate.

Connecticut's reimbursement for primary care dental services average:

- 154% of New York
- 105% of Massachusetts EPSDT (child) rate type
- 77% of Massachusetts Allowed Fee (adult) rate type

Code	**Service**	**CT Child Rate**	**CT Adult Rate**	**Neighboring State Medicaid Fees**					
				NY	**% of NY**	**Mass. Allowed Fee**	**% of Allowed Fee**	**Mass. EPSDT**	**% of EPSDT**
D0120	Periodic oral evaluation est patient	$35	$18.20	$25	***140%***	$20	***91%***	$29	***121%***
D1120	Prophylaxis-child	$46	$23.92	$43	***107%***	$36	***66%***	$51	***90%***
D1208	Topical application of fluoride	$29	$15.08	$14	***207%***	NA		NA	
D1351	Sealant-per tooth	$40	$20.80	$35	***114%***	$28	***74%***	$41	***98%***
D0274	Bitewings - four radiographic images	$48	$24.96	$24	***200%***	$33	***76%***	$43	***112%***

Public Process

Initially, providers and the public were notified about the proposed reductions through the legislative process involved in the adjustments to the state fiscal year 2017 state budget, which

was debated in early and mid-2016 and was approved by the Connecticut General Assembly in May 2016.

In addition, providers and the public were advised of the proposed SPAs via the public notices published in the CT Law Journal (as indicated above, SPA 16-0030 was previously designated as SPA 16-0022) and through provider bulletins that were sent electronically to dental providers and published on the CT Medical Assistance Program website. The State received multiple comments from the dental provider community about the proposed rate reduction, some of which also included alternative suggestions to the rate reduction. While the State has submitted a formal response to the provider community that the proposed SPAs will move forward, based on the public's input, the State recognized the potential impact of a 5% reduction and instead proposes to move forward with the targeted rate reductions and coverage changes in SPA 16-0028 and a 2% reduction for children's dental services in SPA 16-0030.

The Department also received numerous informal comments by telephone regarding these SPAs (especially the initial proposal of a 5% reduction). The majority of the informal discussions focused on alternative potential budget savings options, some of which included the current changes in each of these two SPAs—both the reimbursement reductions and also tightening the soft limits on coverage language described above. Dental providers expressed satisfaction with the ability to provide additional input and suggestions for alternatives to the initial proposal.

Beneficiaries and the public have the ability to continue to raise access concerns both directly to the Department and also to the dental administrative services organization (ASO). The ASO tracks and resolves all access-related issues on a quarterly basis to ensure network adequacy.

Monitoring Procedures and Potential Modifications / Corrective Action

Every three months, the ASO contacts dental provider offices to ensure that each enrolled office is accepting new patients, confirm office hour appointment scheduling times, ensure scheduling parameters can be met for routine, urgent and emergent appointment requests or if any other changes have taken place that may potentially affect member access. In addition, the ASO routinely carries out geo-access mapping to ensure that there are an adequate number of providers available within a ten to twenty-mile radius. Recruitment efforts are maintained in counties and border states where there are fewer providers due to lower population density in certain geographic areas.

If access issues are raised, the Department also assigns staff to help the ASO address and resolve the access issue. Providers also regularly contact the Department directly with concerns regarding fees. If the Department receives feedback, it is promptly reviewed to determine appropriate measures to ensure continued access to care for the specific services.

In addition to these established monitoring procedures, the State is implementing monitoring procedures specific to ensuring compliance with 42 C.F.R. § 447.203(6)(ii). These procedures will include an annual review of unduplicated beneficiaries of dental services, utilization of dental services by county and age, and the number of enrolled dental providers. This data will be compared with baseline data pulled for calendar year 2015 to analyze increases or decreases in the number of beneficiaries receiving services, the overall utilization of services and to assess changes in the number of enrolled dental providers. Based on the results of the analyses and assessment of ongoing beneficiary and provider feedback (consistent with § 447.203(b)(7)), the State will determine whether or not the proposed rate reduction is demonstrating a negative impact on access to dental services. If the State determines that either or both of the proposed SPAs is resulting in a deficiency in access to care or inadequate access, the State will develop and submit a corrective action plan with specific steps and timelines to remedy the deficiencies.

Conclusion

As described above, the Department has carefully considered all of the relevant data regarding utilization, provider network, rate comparison, and other relevant factors in determining to submit these two SPAs. Based on that analysis, the Department has also determined that there remains sufficient access to this service and that such access is expected to continue after implementation of these two SPAs.

CT SPA 16-0029 / AUTISM SPECTRUM DISORDER SERVICES REIMBURSEMENT

ACCESS ANALYSIS

Submitted September 30, 2016

Effective September 1, 2016, Medicaid State Plan Amendment (SPA) 16-0029 proposes to add billing codes that must be used when a technician or Board Certified Assistant Behavior Analyst (BCaBA) provides autism spectrum disorder (ASD) treatment services under the supervision of a qualified Board Certified Behavior Analyst (BCBA) or licensed practitioner. The new codes are CPT code 0364T for the initial 30 minutes and 0365T for all subsequent 30-minute units, which will each be reimbursed at $22.50 per 30-minute unit (equivalent to $45 per hour). Under the previous fee schedule, all ASD treatment services were reimbursed using code H2014 in fifteen-minute units equivalent to $48 per hour. Because this SPA involves a restructuring of reimbursement that may affect access, the Department is submitting this Access Analysis.

In response to the CMS bulletin issued in July 2014, which states that ASD services are coverable under EPSDT and therefore required to be covered pursuant to section 1905(r)(5) of the Social Security Act, the Department began implementing coverage for ASD services effective January 1, 2015. Off-the-clock SPA 15-004 (which has been informally cleared but is delayed pending approval of SPAs that had been delayed due to the recently approved SPA 11-017) reflects the coverage language and the initial reimbursement methodology.

After additional review and analysis, especially given that the program was first implemented in January 2015, the Department is proposing a variety of changes to make the reimbursement methodology for ASD services more precise and comprehensive. Specifically, under pending SPA 16-0004, effective July 1, 2016, the Department is making a number of changes to the reimbursement methodology, including: (1) adding reimbursement for a qualified Board Certified Behavior Analyst (BCBA) or licensed practitioner's observation and direction of a Board Certified Assistant Behavior Analyst (BCaBA) or technician providing ASD treatment services; (2) increasing the rate for ASD treatment services provided directly by BCBAs from the equivalent of $48 per hour to the equivalent of $54.32 per hour; (3) adding a billing code to reimburse for group ASD treatment services provided by a qualified BCBA or licensed practitioner; and (4) adding reimbursement for the development and maintenance of a program book.

Initially, the Department had planned to include the changes in SPA 16-0029 as part of the various changes in SPA 16-0004. However, in response to public input, as described below, the Department delayed the implementation of the changes specified in SPA 16-0029 until September 1, 2016, which required a separate SPA. The Department decided to implement these specific changes for several reasons:

First, the rate of $45 per hour is a more economic and efficient rate for ASD services provided by BCaBAs and technicians, all of whom have less rigorous provider qualifications than BCBAs or licensed practitioners and must provide services under the direction of a qualified BCBA or licensed practitioner. Accordingly, this reimbursement change makes the overall methodology more nuanced and precise in paying higher rates for services provided by individuals with higher amounts of training and expertise.

Second, these rate changes are being made in the context of the reimbursement changes under SPA 16-0004 described above, all of which either increase rates or reimburse for services that were not previously reimbursed at all. In fact, the Department's analysis indicates that when considered together, SPAs 16-0004 and 16-0029 will result in a substantial net increase in expenditures on ASD services. Many of these changes specifically offset any reduction from this SPA because 16-0004 adds or increases reimbursement for various services, in a manner designed to ensure that providers are reimbursed fairly and in a manner designed to encourage access to services.

For all of these reasons, the Department determined that the changes proposed by this SPA increase economy and efficiency, while also increasing the incentives for high quality services. The Department has determined that this SPA will maintain access to services because: (1) the level of reimbursement remains appropriate for ASD treatment services provided by BCaBAs and technicians; (2) the overall level of reimbursement compares favorably to other areas of the Medicaid program; and (3) the reduction from this SPA is expected to be more than offset by the newly reimbursable services and increased rates in SPA 16-0004.

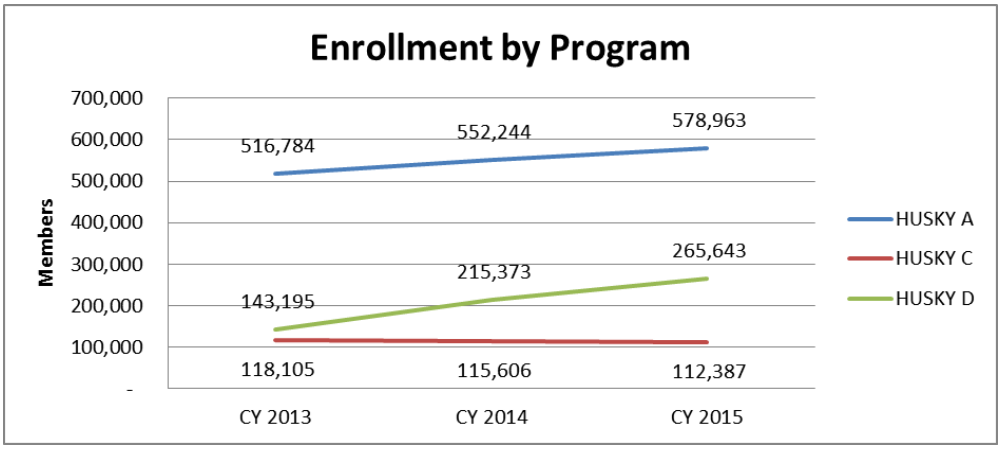
As described below, in accordance with 42 C.F.R. § 447.204(a), prior to the submission of this SPA, the state considered the data collected and analysis performed for this service and the input from beneficiaries, providers, and other affected stakeholders regarding the potential impact of this SPA on access to this service. Further, in accordance with 42 C.F.R. § 447.203(b)(6), the analysis below includes an access review that is being attached to the state's Access Monitoring Review Plan and monitoring procedures to ensure ongoing monitoring of access to this service. As explained below, this analysis demonstrates that there remains sufficient access to this service.

Measures and Analyses

The following measures demonstrate that the state's payment methodology is sufficient to enlist enough providers so that the availability of ASD treatment services is available to Medicaid beneficiaries at least to the extent that those services are available to the general population. The state has determined that this SPA complies with access requirements based on an analysis of the following measures: (1) total number of Medicaid beneficiaries; (2) number of providers performing ASD services; and (3) utilization of ASD treatment services.

Figure 1 shows the total number of Medicaid beneficiaries by eligibility type enrolled for calendar years (CY) 2013 through 2015. Based on this data, HUSKY A and D enrollment increased in the three-year span from CY 2013 through 2015. HUSKY D experienced an 85.5% increase in enrollment, and membership in HUSKY A increased by 12.0% over the three year period. These increases were largely due to the implementation of the Medicaid expansion under Section 2001 of the Affordable Care Act effective on January 1, 2014. During that same period, enrollment in HUSKY C, Connecticut's program for individuals who are aged 65 or older, are blind or have a disability, remained relatively stable with a slight decrease (4.8%) over time.

Figure 1. Total number of Medicaid Beneficiaries by Eligibility Type CY 2013 - 2015



Utilization

Figure 2 show the utilization of the service (ASD treatment services) affected by this SPA (at that time, using only code H2014) for calendar year 2015 by county. This data is not broken out by age of recipient because ASD services are provided only to Medicaid members under age twenty-one, in accordance with EPSDT. Calendar year 2015 data is used because there has been sufficient claims run-out for that data (*i.e.*, there has been sufficient time to account for the time delay from the date of service until claims are submitted, processed, and paid).

Figure 2: Utilization of Autism Spectrum Disorder Treatment Services (Code H2014) – CY 2015

CT County	Billing Providers	Units of Service (unit=15 min)	Unduplicated Recipient Count
Fairfield	5	4,885	59
Hartford	14	41,904	250
Litchfield	-	-	-

Middlesex	3	458	26
New Haven	7	26,837	155
New London	-	-	-
Tolland	2	270	17
Windham	-	-	-
TOTAL:	**31**	**74,354**	**507**

Current methods of providing ASD treatment services are still developing and reimbursement for those services is relatively recent for many payers, including Connecticut's Medicaid program. Specifically, as referenced above, CY 2015 is the first year that Connecticut's Medicaid program implemented coverage and payment for ASD services. Accordingly, the state anticipated that utilization would increase gradually over time. As described below, the state continues to reach out to providers to encourage them to enroll in Connecticut's Medicaid program and provide ASD services.

Based both on claims data from CY 2015 and authorization data to date from CY 2016, utilization continues to increase over time. Specifically, the data regarding the frequency of authorizations per month continues to increase steadily over time from the beginning of the program in early 2015 through the most recent data as of August 2016.

Relatedly, clinical research and practice continue to develop over time. For those reasons, the state understands that there is a statewide (and nationwide) workforce shortage for qualified individuals to perform all ASD services and especially ASD treatment services. This workforce shortage is pervasive in many geographic areas regardless of payer and is not unique to Connecticut's Medicaid program or any Medicaid program. The state continues to work with providers and other stakeholders to implement a statewide autism plan, which is designed to expand the workforce over time and thereby increase provider network capacity to meet the growing demand for these services.

These challenges are particularly acute in geographic areas with lower population density, as indicated in the figures above. The full Access Monitoring Review Plan includes population density for each of the counties. The above data is not a full reflection of the location of where services are provided because a number of providers have multiple locations. In addition, some providers also employ or contract with individual service providers (including BCBAs, BCaBAs and technicians) in various areas of the state, which enables the provider to service various areas of the state. Based on those details, there are services being delivered in all eight of Connecticut counties, even though it is not reflected in the above data because the claims will be recorded as being provided at the provider's primary office location.

Rate Comparison

Medicare does not cover ASD treatment services, so it is not possible to compare rates to Medicare. The Department does not have access to rates paid by commercial insurance plans, which are proprietary. The rates proposed by this SPA are slightly higher than the rates for ASD treatment services for Washington State's Medicaid program ($22 per 30 minutes) or for Florida's Medicaid program ($10 per 15 minutes).

Public Process

The state first provided notice of the change in this SPA through the public notice for SPA 16-0004, which was published on June 28, 2016. This change was also announced in a provider bulletin that was also sent in late June. Unfortunately, typographical errors both in the bulletin and in the fee schedule that was attached to the bulletin led to provider confusion about the extent of the reduction for reimbursement for ASD treatment services provided by BCaBAs and technicians. Specifically, the state inadvertently attached a fee schedule that reflected a substantially lower proposed fee than the $45 per hour that was actually proposed. Providers contacted the Department and, while grateful for the rate increases and reimbursement of additional services in SPA 16-0004, were frustrated by the apparent reduction in payment for ASD treatment services provided by BCaBAs and technicians. In response to those concerns, the state engaged in additional outreach and delayed the implementation of the reduction until September 1, 2016 to enable providers to have additional time to provide feedback.

Both the provider bulletin and the public notice described the reduction and also referenced the federal access regulations. On July 26, 2016, the Department published the public notice for SPA 16-0029 in the Connecticut Law Journal (the state's official register). That public notice specifically referenced the access requirements and invited comments about the SPA in general and also about access issues in particular. The state did not receive any formal public comments about SPA 16-0029. The state also notified providers by provider bulletin about the change in the rate for ASD treatment services provided by BCaBAs and technicians.

Monitoring Procedures and Potential Modifications / Corrective Action

The state's behavioral health ASO has a dedicated ASD services unit that is responsible for utilization review and management and care coordination for ASD services. As part of those duties, the ASO routinely engages with providers to connect beneficiaries who need ASD treatment services with providers, including encouraging providers to continue serving beneficiaries who received services. The state also continues to engage with providers on an ongoing basis to encourage them to enroll in Connecticut's Medicaid program and provide ASD services to beneficiaries.

If access issues are raised, the Department also assigns staff to help the ASO address and resolve the access issue. Providers also regularly contact the Department directly with concerns regarding fees. If the Department receives feedback, it is promptly reviewed to determine appropriate measures to ensure continued access to care for the specific services.

In addition to these established monitoring procedures, the State is implementing monitoring procedures specific to ensuring compliance with 42 C.F.R. § 447.203(6)(ii). These procedures will include an annual review of utilization of ASD treatment services provided by BCaBAs and technicians. This data will be compared with baseline data pulled for calendar year 2015 to analyze increases or decreases in utilization and to assess changes in the number of providers providing ASD services. Based on the results of the analyses, in addition to assessment of ongoing beneficiary and provider feedback (consistent with § 447.203(b)(7)), the State will determine whether or not the proposed rate reduction is demonstrating a negative impact on access to ASD treatment services provided by a BCaBA or technician. If the State determines that the proposed SPA is resulting in a deficiency in access to care or inadequate access, the State will develop and submit a corrective action plan with specific steps and timelines to remedy the deficiencies.

Conclusion

As described above, the Department has carefully considered all of the relevant data regarding utilization, provider network, rate comparison, and other relevant factors in determining to submit this SPA. Based on that analysis, the Department has also determined that there remains sufficient access to this service and that such access is expected to continue after implementation of this SPA.