STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment (SPA)

SPA 25-AF: Hospital Reimbursement for Sickle Cell Disease (SCD) Drugs

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). Public comment information is at the bottom of this document.

Proposed Changes to Medicaid State Plan

Effective on or after October 1, 2025, SPA 25-AF will amend attachment 4.19-A to reimburse hospitals for sickle cell disease drugs separately from the inpatient All Patient Refined Diagnosis Related Group (APR-DRG) payment only when the drugs are approved under the Cell and Gene Therapy Access Model. This change is necessary to comply with the CGT Access Model requirements and is intended to improve equitable access to cell and gene therapies and health outcomes.

Fiscal Impact

Based on current information, DSS estimates that this SPA will increase annual aggregate expenditures by approximately $7,191,000 in State Fiscal Year 2026 and $14,381,000 in State Fiscal Year 2027.

Obtaining SPA Language and Submission of Comments

The proposed SPA is posted on the DSS web site at this link: https://portal.ct.gov/DSS/Health-And-Home-Care/Medicaid-State-Plan-Amendments. The proposed SPA may also be obtained at any DSS resource center, 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: Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105. Please reference "SPA 25-AF: Hospital Reimbursement for Sickle Cell Disease Drugs".

Anyone may send DSS written comments about the SPA. Written comments must be received by DSS at the above contact information no later than **June 26, 2025.**

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

1. Under the transfer payment methodology, the hospital the member is transferred from shall be reimbursed the lesser of the DRG base payment and the transfer DRG base payment. The transfer DRG base payment equals the initial DRG base payment divided by the DRG average length of stay multiplied by the sum of one plus the actual calculated length of stay not to exceed the DRG base payment.
2. The hospital to which the member is transferred shall be reimbursed the full DRG discharge payment without a reduction due to the transfer.

A. Third Party Payments

Any applicable third-party payments are treated as offsets from allowed payments.

B. Payments Outside DRG Base Payment

The following payments are made outside of, and in addition to, the DRG base payment:

1. Direct graduate medical education is reimbursed as a prospective quarterly pass through. Payment for the state fiscal year is based on the Medicaid inpatient percentage of full-time equivalent (FTE) residents multiplied by the approved amount for resident costs, as defined in this section, using the hospital's Medicare cost report, inflated by the inpatient hospital market basket published by CMS. The Medicare cost report for the period two years prior to the current state fiscal year, submitted to the Office of Health Care Access by July1st will be used in the calculations. The approved amount for resident costs is based on worksheet E-4, line 19, column 3; total days are based on worksheet S-3, part I, column 6; and the inpatient percentage is based on inpatient revenue divided by total revenue from worksheet G-2, line 28, columns 1 and 3. Behavioral health days for children under age 19 and nursery days are excluded from Medicaid days in the Medicaid inpatient percentage.
2. Organ acquisition costs for kidneys, livers, hearts, pancreas and lungs are reimbursed at the lower of the statewide average of actual average acquisition cost using the Medicare cost reports, inflated by the inpatient hospital market basket as published by CMS, or actual charges. The Medicare cost report for the period two years prior to the current state fiscal year, submitted to the Office of Health Care Access by July1st will be used in the calculations.
3. Long-Acting Reversible Contraceptives (LARCs) will be reimbursed separately from the APR-DRG payment. A separate outpatient claim may be submitted by the hospital for reimbursement under Revenue Center Code 253 in conjunction with the following codes: J7297, J7298, J7300, J7301 and J7307. Reimbursement for these codes will be based on the CMS approved outpatient hospital reimbursement methodology as described in Attachment 4.19-B.
4. Sickle Cell Disease (SCD) Therapies approved under the Centers for Medicare & Medicaid Services (CMS') Cell and Gene Therapy Access Model with an active supplemental rebate agreement between the manufacturer and Connecticut will be reimbursed separately from the APR-DRG payment. A separate outpatient claim may be submitted by the hospital for the reimbursement of an approved SCD therapy in the manner as specified on the Connecticut Medical Assistance Program website https:\\www.ctdssmap.com/CTPortal/.