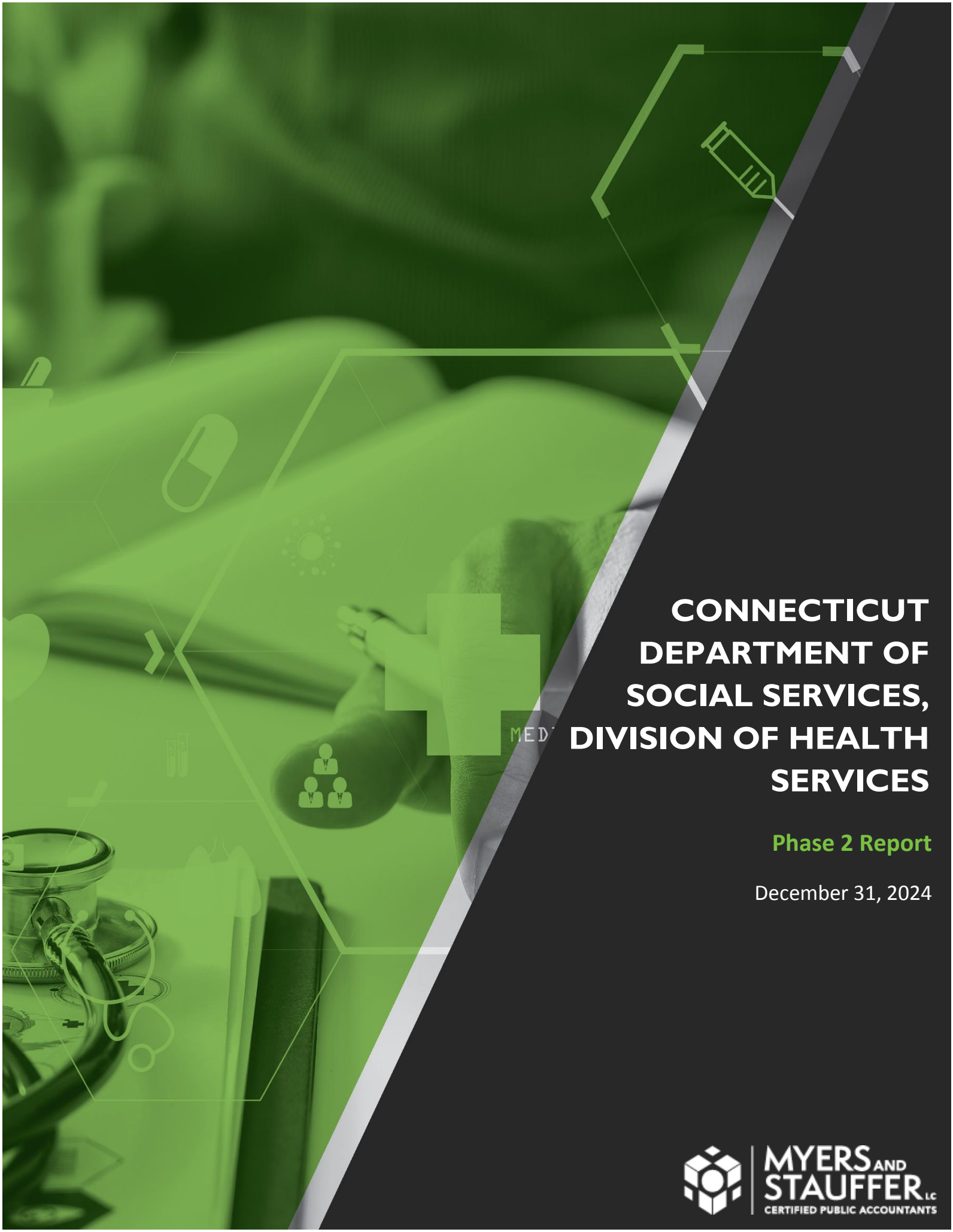

CONNECTICUT DEPARTMENT OF SOCIAL SERVICES, DIVISION OF HEALTH SERVICES

Phase 2 Report

December 31, 2024

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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Executive Summary

Public Act 23-186, *An Act Concerning Nonprofit Provider Retention of Contract Savings, Community Health Worker Medicaid Reimbursement and Studies of Medicaid Rates of Reimbursement, Nursing Home Transportation and Nursing Home Waiting Lists*, requires the Commissioner of Social Services to conduct a two-part study examining Medicaid reimbursement. The Connecticut Department of Social Services (DSS), Connecticut's state Medicaid agency, engaged Myers and Stauffer to conduct this study by evaluating Connecticut Medicaid's rates and rate-setting methodologies for provider reimbursement, including a comparison of the Medicaid rates to rates used by Medicare and by comparison states, and developing a road map for DSS to rationalize payment rates, payment methods, and methodological inputs and assumptions across the spectrum of services. This report provides the results of the provider rate comparisons. This analysis is intended to be used, in conjunction with other available data collected on patient access, to inform a more thoughtful approach to Medicaid rate setting.

DSS specified that Phase 1 work should include the inventory of existing Medicaid program reimbursement rates, payment models, and provider types. As required by Public Act 23-186, Myers and Stauffer focused on a limited number of provider groups for Phase 1 work: physician specialists, dentists, and behavioral health services providers. The review of the payment rates for these services includes recommendations regarding rebasing rates. The Phase 1 report was provided to the legislature in February 2024.

Phase 2 work includes recommendations that will meet the Department's goal of rationalizing rates, payment methods, and methodological inputs and assessments across similar services for the remainder of the programs not addressed in Phase 1, and the development of a road map to meet those goals with an ultimate focus on access needs.

Approach to Developing Benchmarks

For Phase 1, Myers and Stauffer conducted an assessment of the current methodologies and benchmarked Connecticut Medicaid rates to Medicare and peer states, including the basis and components of rates and processes; a review of each of the codes in the fee schedule; and the development of "benchmarks" for comparison. Comparison analyses were based both on Medicare rates, where available, and a five-state average. Myers and Stauffer applied the same methodology for the Phase 2 work, with the exception that the comparison methodology for several services that are generally reimbursed on the basis of provider-specific costs differed, as described further in the report.

Results of Analyses

The benchmarks in this report serve as comparison points and not recommended reimbursement rates. To apply these comparisons for revising or "rebasing" rates, DSS should select which benchmarks to use and how they should be applied. For the purposes of this report, Myers and Stauffer developed an approach that relies on 80% of the Medicare rate where that comparison can be made, and the Five-State Average rate for services that are not listed on any Medicare fee schedule; this was the same approach used in Phase 1 of the rate study. The analysis of codes and fees for this report showed that 51% of the benchmarked codes had a Medicare comparison point. We selected 80% of the Medicare benchmark for illustrative purposes only.

Table 1 illustrates that using 80% of the Medicare and the Five-State Average benchmarks, codes with payments totaling $1.3 billion were benchmarked, broken out as follows: $819.5 million using the Medicare benchmark, and $478.3 million using the Five-State Average rate benchmark. A total of $299.3 million were attributed to non-matched codes, and $4.2 billion were analyzed for the report but not factored into the benchmark. With an annual budget of approximately $10 billion, the remaining $4.5 billion not included in the study includes pharmacy services, reimbursement for which is determined by a complex set of policies and both the federal and state levels that make comparisons difficult; and services that are funded through Certified Public Expenditures (CPEs), which are funds spent by the government on Medicaid-eligible services and items and then certified by the State for the purposes of claiming federal reimbursement. Myers and Stauffer further determined that an estimated additional amount of $300.5 million ($150.3 million state share or 50% state share, a conservative estimate as certain populations and service categories have a higher match rate) would be needed if DSS applied those benchmarks.[1] In *Table 1,* yellow identifies those services that were included in the Phase 1 report, green denotes Phase 2 services, and blue identifies services which were analyzed in Phase 2, but for which a benchmark was not determined.

[1] Calculated as 50% to account for the FMAP as a conservative estimate of the state share necessary. Although 50% FMAP is the default FMAP for Connecticut's Medicaid program, certain populations and service categories have a higher FMAP.

Table 1: Benchmark Summary Analysis

Benchmark Summary Analysis $ in Millions							
Fee Schedule	**Current Expenditures**	**Expenditures at 80% of Medicare**	**Expenditures at 100% Five- State Comparison**	**Expenditures Associated with Non-Matched Codes**	**Total Expenditures at Benchmark[2]**	**Amount Expenditures would Increase**	**Percent Increase over Current Expenditures**
Physician Outpatient Non Facility[3]	$312.0	$373.2		$51.0	$424.2	$112.2	36.0%
Physician Outpatient Facility	$22.7	$30.4		$0.0	$30.4	$7.7	33.9%
Physician - Anesthesia	$16.8	$21.1		$0.0	$21.1	4.3	25.6%
Physician - Radiology	$45.6	$45.7		$0.9	$46.6	1.0	2.2%
Physician Surgery Non-facility	$77.8	$102.7		$3.2	$105.9	$28.1	36.1%
Physician Surgery Facility	$16.2	$21.3		$0.0	$21.3	$5.1	31.5%
Autism Services	$50.9		$65.0	$0.3	$65.0	$14.1	27.8%
Behavioral Health Clinic	$39.1		$81.4	$3.4	$84.8	$45.7	116.9%
Dental[4]	$179.3		$177.4	$0.9	$178.3	$0.0	0.0%
Acupuncture	$1.9	$2.8		$0.0	$2.8	$0.8	43.6%
ASC	$9.8	$12.8		$0.2	$12.9	$3.2	32.3%
Audiology & Speech Pathology	$2.0	$3.2		$0.1	$3.3	$1.3	64.1%
Chiropractor	$0.5	$0.7		$0.0	$0.7	$0.3	50.9%
Clinic- Outpatient Hospital Behavioral Health	$98.3		$90.9	$22.6	$113.5	$15.2	15.4%
Clinic- Medical	$1.4	$1.7		$0.2	$1.9	$0.5	33.1%
Clinic-Rehab	$14.8	$14.3		$0.6	$15.0	$0.2	1.5%
Dialysis	$10.8	$0.2		$10.5	$10.8	$0.0	0.0%

[2] Only includes increases for those codes with expenditures that would be below 80%. There is no estimated increase for those codes already above the benchmark. Codes not matched to a benchmark are represented at their current expenditure level.
[3] CMS makes the non-facility and facility designations and sets the Medicare fee higher for some codes because the practitioner is paying for overhead and equipment costs.
[4] Connecticut rates are greater than the Five-State Average rate when both adult and pediatric fee schedules were combined, resulting in no net increase.

Benchmark Summary Analysis $ in Millions							
Fee Schedule	**Current Expenditures**	**Expenditures at 80% of Medicare**	**Expenditures at 100% Five- State Comparison**	**Expenditures Associated with Non-Matched Codes**	**Total Expenditures at Benchmark[2]**	**Amount Expenditures would Increase**	**Percent Increase over Current Expenditures**
Durable Medical Equipment (DME)-Cures Act [5]	$26.2	$11.3		$16.9	$28.2	$2.0	7.6%
DME (Non-Cures Act)[6]	$2.1	$0.0		$2.1	$2.1	$0.0	0.2%
Family Planning Clinics	$8.0		$9.2	$0.8	$10.1	$2.1	25.8%
Hearing Aid and Prosthetic Eye (Cures Act)	$2.5		$3.1	$0.9	$4.1	$1.6	65.8%
Home Health (Procedure Codes)	$187.5		$50.1	$155.4	$205.5	$18.0	9.6%
Independent Radiology	$1.7	$1.1		$0.7	$1.8	$0.1	6.7%
Laboratory	$55.3	$66.1		$0.7	$66.8	$11.4	20.7%
Medical Surgical Supplies (Cures Act)	$15.6	$14.2		$1.4	$15.6	$0.0	0.0%
Medical Surgical Supplies (Non-Cures Act)	$24.1	$0.0		$24.1	$24.1	$0.0	0.0%
Enteral & Parenteral (Cures Act)	$2.8	$2.9		$0.1	$2.9	$0.1	3.8%
Naturopath	$0.7		$1.2	$0.0	$1.2	$0.4	54.1%
Optician/Eyeglasses	$3.7	$4.8		$1.4	$6.2	$2.5	66.1%
Physical and Occupational Therapy	$3.9	$6.7		$0.1	$6.8	$3.0	76.0%
Prosthetic & Orthotic	$12.1	$15.2		$0.7	$15.9	$3.8	31.9%
Transportation	$51.3	$67.0		$0.1	$67.1	$15.9	31.0%

[5] The Cures Act prohibits federal Medicaid reimbursement to states for certain DME expenditures that are, in the aggregate, in excess of what Medicare would have paid for such items. Not all codes are included and for the purposes of comparison are separated for the analysis.

[6] The utilization for the procedure codes listed on the CT MEDS-MISC Fee Schedule was combined with the DME (non-Cures) amounts.

Benchmark Summary Analysis $ in Millions							
Fee Schedule	**Current Expenditures**	**Expenditures at 80% of Medicare**	**Expenditures at 100% Five- State Comparison**	**Expenditures Associated with Non-Matched Codes**	**Total Expenditures at Benchmark[2]**	**Amount Expenditures would Increase**	**Percent Increase over Current Expenditures**
Chemical Maintenance	$52.1				$52.1		
Federally Qualified Health Centers	$280.6				$280.6		
Home Health (Revenue Codes)[7]	$4.7				$4.7		
Hospice	$6.5				$6.5		
ICF	$74.0				$74.0		
Inpatient Hospital (DRG)[8]	$928.5				$928.5		
Inpatient Hospital (Per Diem)	$140.1				$140.1		
Nursing Facilities	$1,622.9				$1,622.9		
Outpatient Hospital	$1,052.4				$1,052.4		
PRTF	$11.9				$11.9		
Total	**$5,471.1**	**$819.5**	**$478.3**	**$299.3**	**$5,770.7**	**$300.5**	**5.5%**
State Share[9]	**$2,735.6**	**$409.7**	**$239.2**	**$149.7**	**$2,885.3**	**$150.3**	

In a separate rate study conducted to examine the home and community-based services (HCBS) waiver rates, rates were modeled to determine the fiscal impact by service type of implementing rate methodology updates using current data. This rate study was also completed in two phases. The first phase studied the HCBS waivers operated by DSS and the second phase examined the waivers operated by the Department of Developmental Services (DDS).

Table 2 provides a breakdown of the modeled payments for DSS waivers by service type.

[7] Home Health services reported with procedure codes were compared and benchmarked, however, some home health services were reported with revenue codes and because states use these revenue codes differently, they were not comparable across states; these codes were not benchmarked.

[8] Estimated expenditures based on DRG claim counts, 2024 DRG weights, and average 2024 DRG payment rates, without additional payments made to providers outside the DRG rates.

[9] Calculated as 50% to account for the FMAP as a conservative estimate of the state share necessary. Although 50% FMAP is the default FMAP for Connecticut's Medicaid program, certain populations and service categories have a higher FMAP.

Table 2: HCBS Rate Study Phase 1 Fiscal Impact by Service Type

HCBS Rate Study Phase 1 DSS Fiscal Impact by Service Type				
	Baseline Model	Modeled Payments	Difference	% of Fiscal Impact
Total Modeled Payments	$706,840,992	$925,250,568	$218,409,576	
Categories expanded below:	**$663,980,160**	**$866,508,964**	**$202,528,804**	**93%**
Personal Care	$396,025,280	$517,400,275	$121,374,995	56%
Tiered Case Management	$31,489,039	$57,616,440	$26,127,401	12%
Companion Services	$44,812,419	$61,067,904	$16,255,485	7%
Adult Family Living	$125,969,407	$138,828,601	$13,132,194	6%
Independent Living Skills Training	$36,764,180	$47,079,310	$10,315,130	5%
Adult Day Health	$12,577,169	$20,873,300	$8,296,132	4%
Recovery Assistant	$16,615,666	$23,643,133	$7,027,467	3%
Other Categories	$42,860,833	$58,741,604	$15,880,771	7%
Total	**$706,840,992**	**$925,250,568**	**$218,409,576**	**100%**

Table 3 provides a breakdown of the modeled payments for DDS waivers by service type.

Table 3: HCBS Rate Study Phase 2 DDS Fiscal Impact by Service Type

HCBS Rate Study Phase 2 DDS Fiscal Impact by Service Type				
	Baseline Model	Modeled Payments	Difference	% of Fiscal Impact
Total Modeled Payments	$842,314,887	$1,023,364,133	$181,049,246	
Categories expanded below:	**$835,674,264**	**$1,014,160,549**	**$178,486,285**	**96%**
Community Living Arrangement	$425,016,956	$520,776,149	$95,759,193	53%
Individualized Home Supports	$43,216,742	$70,139,979	$26,923,237	15%
Continuous Residential Supports	$119,281,896	$141,764,110	$22,482,215	12%
Day Support Options	$180,537,218	$201,678,766	$21,141,548	12%
Supported Employment	$52,357,042	$59,887,054	$7,530,012	4%
Other Categories	$6,640,623	$9,203,584	$2,562,961	4%
Total	**$842,314,887**	**$1,023,364,133**	**$181,049,246**	**100%**

Findings and Recommendations Regarding Rebasing and Updating Fee Schedules

Based on the review of the metrics regarding the comparisons of Connecticut Medicaid fees to the benchmarks as described above, and a review of current methodologies, Myers and Stauffer has identified the following findings and recommendations:

Table 4: Summary of Findings and Recommendations

Findings and Recommendations		
Priority Area	**Findings**	**Recommendations**
Fee Schedule Development and Use	• Documentation of Connecticut Medicaid methodologies and fee schedule approaches is inconsistent. • Connecticut Medicaid is inconsistent in the frequency of, basis and rationale for, and implementation of updates across fee schedules. • In some fee schedules, Connecticut Medicaid uses different service definitions and coding systems in comparison to Medicare and the comparison states and since Connecticut Medicaid has not consistently and regularly reviewed or updated fee schedules, there is no uniform explanation as to why some codes are used in place of others.	• Use Medicare as the benchmark for fee schedules and update those fee schedules periodically and to a more current year. • Create greater provider equity by rebasing the fee schedules using a consistent percentage of the current Medicare Physician Fee Schedule (PFS) or other relevant Medicare fee schedule. • Develop a timetable for the review and/or update of rates, and for rebasing rates to achieve greater equity across providers. Update rates each year to maintain a consistent percentage of Medicare rates as those rates are updated each year. • For rates where Medicare does not provide a methodologically sound approach for updating rates, update rates using other state Medicaid programs' rates initially, and adopt independent rate models in future years. • Consider rebalancing, i.e., revising services that are included on a particular fee schedule, or shifting greater payments to some services while decreasing payments for other services, to further state policy and program goals.

Findings and Recommendations		
Priority Area	**Findings**	**Recommendations**
Cost-Based and Provider-Specific Reimbursement	• Comparisons of some services using an alternative analyses approach provide insight into rate methodologies but are limited in developing benchmarks. • Connecticut Medicaid generally updates methodologies and payment rates somewhat more consistently and regularly for many of the services where fee schedules are based on providers' costs.	• For rate methodologies that were analyzed using an alternative approach, continue the rate updates and rebasing as currently completed to maintain the integrity of the methodologies and resulting fee schedules.
Fee Schedule Maintenance	• Connecticut Medicaid has established multiple fee schedules for groups of providers that are generally included in one overall fee schedule in the comparison states and Medicare. • The review of the procedure codes and fees overall indicated there was no utilization of services for many codes in 2023.	• Combine all the fee schedules paid using the Medicare Physician Fee Schedule (PFS) into one fee schedule. Do the same for the Connecticut Medicaid fee schedules that are based on the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule and for others where services are provided by comparable providers, for example, Transportation.
Access	• DSS' medical administrative services organization monitors access to services using geo-mapping and other tools, and also reviews complaints regarding member access; targeted access issues are addressed as they arise and are not considered to be caused by fee schedule issues.	• Continue to monitor access issues and ensure investments made improve Medicaid member experiences and access to services as fee schedule methodologies and rates are changed.
Value-Based Purchasing Incentives	• DSS has numerous ad-hoc initiatives that are in process to address specific needs but has not yet established a process for systematic and routine updates across all program areas.	• Consider expanding the implementation of various types of alternative payment methods for different categories of providers selected by DSS that include incentives to providers to improve the quality and overall value of services provided to members, including improving cost containment.

Findings and Recommendations		
Priority Area	**Findings**	**Recommendations**
HCBS Waiver Services	• Service utilization is predominantly in residential supports rather than in community integration services. • Average per person costs in Connecticut are higher than average per person costs of northeastern states. • Waiver eligibility and service planning are not consistent with waiver best practices. DSS does not use a standardized evidenced based assessment tool to aid in eligibility and person-centered planning.	• Examine the current service array, including utilization of services, service descriptions, and policies that drive utilization to determine that they reflect current program goals and provide for community integration. • Identify population-based goals for each waiver, as well as procedures and administrative models to support those goals. • Examine the current process for assessing waiver members and consider adoption of standardized and validated tools.

The remainder of the report includes a detailed analysis of each service area and fee schedule as well as a discussion of observations, findings and recommendations. *Appendix A* provides a description of the methodologies used for fee schedules by Connecticut and the comparison states. *Appendix B* includes a description of any data adjustments made as part of the analysis and *Appendix C* includes a description of potential alternative payment methods and quality initiatives the state may wish to consider. *Appendix D* includes the HCBS waiver rate study report.

Selected Services

Phase 1 services, as specified by Public Act 23-186, included physician, behavioral health, dental, and autism services. For Phase 2, Myers and Stauffer reviewed fee schedules for the following providers/services as illustrated in *Table 5.*

Table 5: Phase 2 Services and Fee Schedules

Phase 2 Services and Fee Schedules		
Providers/Services		
Acupuncture	DME	MEDS-Misc
Ambulatory Surgical Center	FQHC	Naturopath
Audiology and Speech	Hearing Aid/Eye	Nursing Facility
Chemical Maintenance	Home Health	Optician/Eyeglasses
Chiropractor	Hospice	Physical and Occupational Therapy
Chronic Disease Hospital	Hospital Outpatient/Inpatient	Prosthetic/Orthotic
Clinic and Outpatient Hospital Behavioral Health	ICF (Private)	PRTF (Private)
Clinic - Family Planning	Independent Radiology	Transportation Air Ambulance
Clinic-Medical	Laboratory	Transportation Basic/Advanced
Clinic-Rehab	Medical Surgical Supplies	Transportation Critical Helicopter
Dialysis	MEDS-Enteral/Parenteral	--

Myers and Stauffer reviewed available documentation regarding Connecticut rate methodologies and rates for the above services, and methodologies used by Medicare and other states for those services. *Appendix A* provides a summary of those comparisons. Information from comparison states is gathered through publicly available and accessible documents. Individual states may have more detailed or updated information that may not be reflected in this analysis. The information here is intended only to provide context to the discussion and is not intended to fully represent all the nuances of the individual rate setting processes.

Waiver services were studied as part of another initiative to review the rate methodology for the home and community-based services under the 1915(c) waivers. That full study is included in Appendix D and the results are incorporated wherever possible in the final financial impact modeling of this report. The waivers included are:

- *Autism;*

- *Home Care;*
- *Personal Care Assistance;*
- *Acquired Brain Injury;*
- *Mental Health (under Department of Mental Health and Waiver Services);*
- *Comprehensive Supports (under DDS);*
- *Individual and Family Support (under DDS);*
- *Employment and Day Supports (under DDS).*

Some fee schedules were not included in the benchmarking analysis. These programs were excluded for a variety of reasons, but generally because they include either very new services, services with no utilization, or services for which rates had been recently updated. *Table 6* provides a list of excluded services and the rationale for exclusion.

Table 6: Services Not Included in Study

Services and Fee Schedules Not Included	
Fee Schedule Name	**Rationale**
Acquired Brain Injury (Case Management, Fiduciary, and Service Provider)	Part of a recent or ongoing study.
Residential Care Home (RCH)	RCH is a residential setting, not a Medicaid covered service.
Psychiatric Residential Treatment Facility (PRTF) -- Public	Rate study was recently completed.
Intermediate Care Facilities (ICFs) – Public	ICF public rates are cost-based and were recently updated.
Connecticut Housing Engagement and Support Services	Program undergoing design and policy review.
Free Standing Birthing Center	Program characteristics not comparable to other comparison points; benchmarks and low overall program size and utilization.
Free Standing Substance Use Disorder Residential Treatment Facilities	Newly established service.
Integrated Care for Kids (InCK) Targeted Case Management (TCM)	Newly established service.
Special Services – Birth to Three Years	Rate study was recently completed.
Targeted Case Management Services (non-contracted)	Funding is financed through appropriations to a state agency other than DSS through a Certified Public Expenditure (CPE) methodology.
Transportation - Non-Emergency Medical	Contract is competitively bid.
Transportation - Travel Agent	Services are manually priced.
Violence Prevention Professional	Newly established service.

Services and Fee Schedules Not Included	
Fee Schedule Name	**Rationale**
Pharmacy	Payments are determined by a complex set of policies, at both the federal and state level, that draw on price benchmarks such as acquisition costs, best prices, and other factors. States also receive rebates from pharmaceutical manufacturers that offset the federal and state costs of many outpatient drugs, and that are based in part on the volume of drugs used. States also use the 340B Drug Pricing Program, which allows eligible health care organizations to purchase outpatient drugs at a discount from pharmaceutical programs, reducing the actual price paid for some drugs.

Comparison of Fee Schedules

Approach

As described in the Phase 1 report, Myers and Stauffer selected five state Medicaid programs for comparison of Medicaid fee schedules to Connecticut's fee schedules. The selected states were Maine, Massachusetts, New Jersey, New York, and Oregon. While there is no one-to-one match of states to Connecticut, economic indicators such as geographic practice indices (physician services), cost of living indices, CMS wage indices, and behavioral health wage comparisons suggest comparability across these states. Of the comparison states, Maine, as does Connecticut, operates a fee-for-service payment system; the other states have risk-based managed care, but continue to update, publish, and maintain their fee schedules. All states except Oregon are geographically close; DSS selected Oregon as an additional state for review because it has adopted a number of Value-Based Payment (VBP) and alternative payment methods that provide insight into innovative payment program design.

Myers and Stauffer also compared Medicaid rates to Medicare rates (national rates adjusted for Connecticut). Medicare often serves as the comparison point for states evaluating their payment methodologies and rates. The analysis for Phase 2 services represents a later time period and the rates and claims data reflect current information, more recent than the data used for the Phase 1 review period.

In understanding the comparisons of rates across state Medicaid agencies and Medicare, it is noted that government payers maintain more detailed information about fee schedules and underlying payment policies that may not be reflected in the information obtained from published fee schedules. Methodologies that Medicare and other state Medicaid programs use, and the resulting rates, are specific to their overall policies and economic environment, and there are policy decisions and unpublished context underlying the rate values. For example, a state may intentionally have a low rate for a certain procedure code to encourage utilization of another code or another service. The rate comparisons presented in this report did not include a comparison of underlying rate assumptions for rates from other payers or an analysis of broader state economic factors, as doing so would have been outside the scope of this project. The rate comparison serves to identify where Connecticut Medicaid rates fall in comparison to rates from a selection of other government payers.

Further, the comparison of Connecticut rates to Medicare rates and a sample of other states' rates is not intended to suggest a desired fee schedule amount or level of reimbursement. Ultimately, those decisions are based on access needs and in accordance with state legislation that determines Medicaid agency budgets based on state revenues, and appropriations are authorized by the legislature and provide agencies with authority to expend funds. In addition, the federal government's share of a state's

expenditures through Federal Medical Assistance Percentage (FMAP) varies by state and provides differing levels of federal support across states.

Health care payers, including Medicare and state Medicaid agencies, differ in how they determine benefits and define services, the limitations they place on services, who is eligible for the services, which providers deliver the services, and numerous other factors that affect reimbursement methodologies and fees. The comparison instead provides a benchmark—a standard or point of reference against which the Connecticut rates may be compared or assessed and provides the opportunity for Connecticut Medicaid to compare relative payment rates across all provider services. The benchmark, therefore, should be viewed as a comparison point and not a recommended reimbursement rate. Nor are rate comparisons alone determinative of patient access, and therefore, this information must be understood in the context of broader Medicaid access and performance indicators.

Myers and Stauffer prepared a series of analyses for each fee schedule to develop comparisons to the Medicaid fee schedules of the five states and to Medicare. In preparation of the analyses and development of the rate comparisons, a number of adjustments were made to the fee schedule information and the claims data used in the analyses. These adjustments are detailed in *Appendix B* to this report.

Myers and Stauffer applied different approaches to the analysis of seven service categories: Chemical Maintenance, Federally Qualified Health Centers (FQHCs), Hospice, Hospitals, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs) (Private), Nursing Facilities, and Private Psychiatric Residential Treatment Facilities (PRTFs). Rates for these service categories are generally provider specific, cost-based, and/or based on patient-specific classifications described below, which make comparisons difficult. The following factors describe the difficulties in comparing specific fee schedules.

- *Use of individual provider costs as a basis for rates: cost and patient-specific data is generally not available from comparison states. These rates may also be adjusted to reflect patient specific acuity or service criteria.*
- *Use of grouper software to classify services for rate development: different grouper software results in assignment of claims to different classifications that do not compare to each other for comparison states.*
- *Comparability to Medicare: Medicare may apply different adjustments to rates that reflect individual patients' needs, may utilize a different grouper software, or may not provide coverage for the service at all.*
- *Other financing considerations: states may make policy decisions such as utilizing an APM for a service, including/excluding a service in a supplemental payment program, or making*

policy decisions to phase a service in or out. This also includes services where the rate is established by CMS.

Table 7 outlines the services that were analyzed using an alternative method of comparison to accommodate these issues.

Table 7: Alternative Analysis by Factor

Alternative Analysis Factors				
Service/Fee Schedule	**Cost-Based Rates**	**Use of Grouper Software**	**Medicare Comparability**	**Other Financing Considerations**
Chemical Maintenance Clinics	X		X	X
FQHC	X			X
Hospice			X	X
Inpatient Hospital	X	X	X	X
Outpatient Hospital	X	X	X	X
ICF (Private)	X		X	
Nursing Facilities	X		?	
PRTF (Private)	X		X	

To fulfill the requirements of Public Act 23-186, Myers and Stauffer compared Connecticut's rates to the rates of comparison states and to Medicare using a more limited methodology and provided context for the interpretations of those comparisons:

- For Chemical Maintenance, an analysis of the service and methodology is provided.
- For FQHCs, a limited number of data points to other states' data points are compared only where they were comparable.
- For Hospice, CMS defines the minimum rate for each state and, as such, comparisons are not useful. The CMS defined methodology is provided below.
- For hospital services, Connecticut base rates (i.e., average cost per discharge) are compared to the base rates of other states and Medicare only where the same software is used to assign discharges to diagnosis related groups (DRGs).
- For ICFs, nursing facilities, and PRTF private facilities, Connecticut base rates are compared to the base rates of other states.

A Five-State Comparison benchmark rate or a Medicare benchmark for the above services was not created to estimate the impact of changing the Connecticut rates because of the difficulties associated with the comparisons.

Number of Codes and Expenditures Compared

Myers and Stauffer compared codes representing about 31 percent of all Connecticut Medicaid expenditures. Codes that were not compared resulted from the lack of matching codes across states or Medicare, a relatively low number of observations, exclusion from the study, and other factors detailed in the report. In the comparison of Connecticut Medicaid codes and rates to the Five-State Average rate, Myers and Stauffer compared codes representing about 81 percent of the benchmarked expenditures as illustrated in Figure 1.

Figure 1: Expenditure Amounts by Benchmark

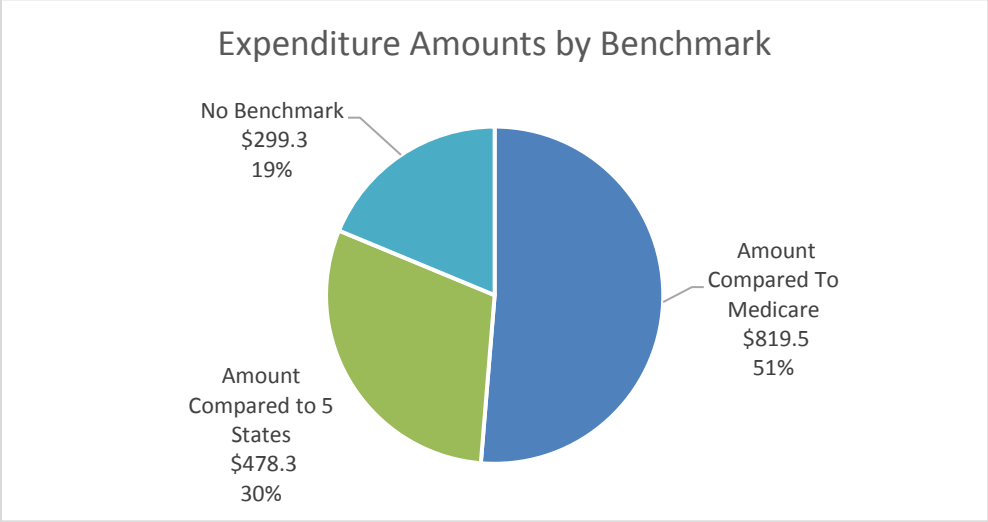
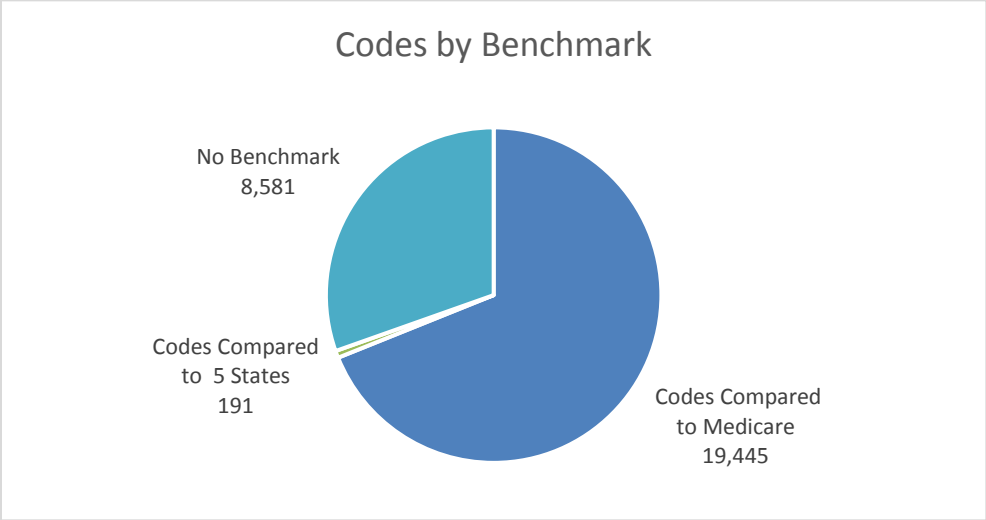


Figure 2 further identifies the number of codes that were benchmarked and shows that the majority of codes were benchmarked to Medicare; 8,581 codes were not matched to Medicare codes or the codes of the comparison states.

Figure 2: Codes by Benchmark



Rate Comparisons

For Phase 2 services, Myers and Stauffer conducted rate comparisons similar to the ones conducted in Phase 1; however, claims data and rates were updated to use the more current time period. Myers and Stauffer provide comparisons regarding Connecticut Medicaid rates to the average of the rates from five states and to the Medicare rate, and the range of comparison percentages across codes, as well as the number of unique codes included in the comparisons.[10]

In the analyses of the comparisons of Connecticut codes to the Five-State Average rates, the number of codes where rates are above and below the benchmarks are provided to show how rates within a fee schedule vary. Finally, the report provides current expenditures, which represent the expenditures shown on the claims data reviewed and exclude expenditures for claims that are not reviewed because they were identified as outliers in the comparisons or because there were no matches between Connecticut code(s) and the comparison states' code(s). (Appendix B provides additional details.)

Acupuncture

Myers and Stauffer reviewed 12 codes and rates for Acupuncture services in the Connecticut Medicaid program, as shown in *Table 8,* and compared the rates to rates for Medicaid programs in the states of

[10] Connecticut Medicaid uses various modifiers to codes and rate types for rate determination process, and we counted as a unique code each code on its own, plus each modifier to the code and each rate type.

Massachusetts, New Jersey, New York, and Oregon. Connecticut Medicaid rates for 13 codes were also compared to Medicare rates.

Table 8: Summary of Acupuncture Fee Comparisons

Summary of Acupuncture Fee Comparisons		
	CT compared to Five-State Average[11]	**CT compared to Medicare**
Comparison Rate Percentage Range	69.1% - 100.1%	45.2% - 96.3%
Average Comparison Rate Percentage	82.7%	58.1%
Count of Distinct Codes Analyzed	12	13
Count of Connecticut Codes per Fee Schedule	13	13
Percentage of CT Codes Below Comparison Rate	91.7%	100.0%
75 - 100% Below the Comparison Rate	66.7%	7.7%
50 - 74% Below the Comparison Rate	25.0%	76.9%
25 - 49% Below the Comparison Rate	0.0%	15.4%
0 - 24% Below the Comparison Rate	0.0%	0.0%
Percentage of CT Codes Above the Comparison Rate	8.3%	0.0%
1 - 24% Above the Comparison Rate	8.3%	0.0%
25 - 49% Above the Comparison Rate	0.0%	0.0%
50 - 74% Above the Comparison Rate	0.0%	0.0%
75 - 99% Above the Comparison Rate	0.0%	0.0%
100% and Above the Comparison Rate	0.0%	0.0%
Estimated Current Expenditures	$1,834,561	N/A
Amount Excluded (No Match or Outlier)	$81,249	N/A
Estimated Expenditures at Five-State Benchmark	$2,074,748	N/A
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	$240,187	N/A
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	13.1%	N/A
Estimated Current Expenditures	N/A	$1,915,810
Amount Excluded (No Match)	N/A	$0
Estimated Expenditures at Medicare Rate	N/A	$2,752,029
Difference Between Estimated Current Expenditures and Estimated Expenditures at Medicare Rate	N/A	$836,220
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Medicare Rate	N/A	43.6%

Observations

[11] The Medicaid program in Maine does not cover services provided by acupuncturists, so the Comparison Rate is based on 4 states.

Connecticut Medicaid rates are overall lower than the Five-State Average rate and Medicare rates. Fees were originally determined using the Connecticut Medicaid Physician Office and Outpatient Fee Schedule, and the Independent Physical Therapy and Occupational Therapy fee schedule rates for the same codes.

Ambulatory Surgical Center

Myers and Stauffer reviewed 2,452 codes and rates for Ambulatory Surgical Center (ASC) services in the Connecticut Medicaid program, as shown in *Table 9,* and compared the rates to rates for Medicaid programs in the states of Maine, Massachusetts, New Jersey, and Oregon.

Rates for 2,527 Connecticut codes were reviewed and compared to Medicare rates.

Table 9: Summary of Ambulatory Surgical Center Fee Comparisons

Summary of Ambulatory Surgical Center Fee Comparisons		
	CT compared to Five-State Average[12]	**CT compared to Medicare**
Comparison Rate Percentage Range	2.4% - 142.1%	1.3% - 485.5%
Average Comparison Rate Percentage	58.7%	39.9%
Count of Distinct Codes Analyzed	2,452	2,527
Count of Connecticut Codes per Fee Schedule	2,636	2,636
Percentage of CT Codes Below Comparison Rate	90.7%	97.3%
75 - 100% Below the Comparison Rate	16.2%	6.0%
50 - 74% Below the Comparison Rate	35.7%	14.0%
25 - 49% Below the Comparison Rate	27.4%	47.2%
0 - 24% Below the Comparison Rate	11.3%	30.0%
Percentage of CT Codes Above the Comparison Rate	9.3%	2.7%
1 - 24% Above the Comparison Rate	7.0%	1.2%
25 - 49% Above the Comparison Rate	2.4%	0.4%
50 - 74% Above the Comparison Rate	0.0%	0.6%
75 - 99% Above the Comparison Rate	0.0%	0.0%
100% and Above the Comparison Rate	0.0%	0.5%
Estimated Current Expenditures	$8,423,895	N/A
Amount Excluded (No Match or Outlier)	$1,335,866	N/A
Estimated Expenditures at Five-State Benchmark	$9,942,602	N/A
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	$1,518,707	N/A
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	18.0%	N/A

[12] The Medicaid program in New York pays for ASC services using a methodology that does not allow for comparison to Connecticut, so the Comparison Rate is based on 4 states.

Summary of Ambulatory Surgical Center Fee Comparisons		
	CT compared to Five-State Average[12]	CT compared to Medicare
Estimated Current Expenditures	N/A	$9,606,040
Amount Excluded (No Match)	N/A	$153,721
Estimated Expenditures at Medicare Rate	N/A	$12,761,154
Difference Between Estimated Current Expenditures and Estimated Expenditures at Medicare Rate	N/A	$3,155,114
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Medicare Rate	N/A	32.8%

Observations

Connecticut Medicaid rates for ASC services are overall lower than the Five-State Average rate and Medicare rates. Across codes, there is a wide variation in the comparison rates for Connecticut and the Five-State Average Rate, and also in comparison to Medicare. Rates for ASC services were originally developed using 100% of the Medicare ASC Surgery fee schedule that was in place in 2007; this methodology was developed based on a combination of ASC charge and cost data. In January 2008, Medicare implemented a new ASC payment system. Some of the comparison states also use the newer Medicare ASC methodology. Under this approach, payments for ASC services were linked to payments made to Hospital Outpatient Prospective Payment System rates, and were determined as approximately 60% of those rates.[13] The more recent Medicare methodology and the lack of updated Connecticut rates creates a wide variation in Connecticut rates in comparison to Medicare.

Audiology and Speech

Myers and Stauffer reviewed 76 codes and rates for independent Audiology and Speech Pathology services in the Connecticut Medicaid program, as shown in *Table 10*, and compared the rates to rates for Medicaid programs in the states of Maine, Massachusetts, New Jersey, New York, and Oregon. Connecticut Medicaid rates for 81 codes were also compared to Medicare rates.

Table 10: Summary of Audiology and Speech Fee Comparisons

Summary of Audiology and Speech Fee Comparisons		
	CT compared to Five-State Average	CT compared to Medicare
Comparison Rate Percentage Range	25.1% - 144%	10.2% - 780.4%
Average Comparison Rate Percentage	81.4%	99.1%
Count of Distinct Codes Analyzed	76	81
Count of Connecticut Codes per Fee Schedule	92	92
Percentage of CT Codes Below Comparison Rate	77.6%	82.7%

[13] https://resdac.org/articles/medicare-provider-types-ambulatory-surgical-centers-ascs

Summary of Audiology and Speech Fee Comparisons		
	CT compared to Five-State Average	**CT compared to Medicare**
75 - 100% Below the Comparison Rate	34.2%	3.7%
50 - 74% Below the Comparison Rate	28.9%	32.1%
25 - 49% Below the Comparison Rate	14.5%	39.5%
0 - 24% Below the Comparison Rate	0.0%	7.4%
Percentage of CT Codes Above the Comparison Rate	22.4%	17.3%
1 - 24% Above the Comparison Rate	11.8%	2.5%
25 - 49% Above the Comparison Rate	10.5%	2.5%
50 - 74% Above the Comparison Rate	0.0%	3.7%
75 - 99% Above the Comparison Rate	0.0%	0.0%
100% and Above the Comparison Rate	0.0%	8.6%
Estimated Current Expenditures	$1,924,543	N/A
Amount Excluded (No Match or Outlier)	$65,453	N/A
Estimated Expenditures at Five-State Benchmark	$2,575,331	N/A
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	$650,788	N/A
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	33.8%	N/A
Estimated Current Expenditures	N/A	$1,924,196
Amount Excluded (No Match)	N/A	$65,801
Estimated Expenditures at Medicare Rate	N/A	$3,200,600
Difference Between Estimated Current Expenditures and Estimated Expenditures at Medicare Rate	N/A	$1,276,404
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Medicare Rate	N/A	66.3%

Observations

Connecticut Medicaid rates are overall lower than the Five-State Average rate and the Medicare rates. Across codes, there is a wide variation in the comparison rates for Connecticut and the Five-State Average rate, and also in comparison to Medicare rates. Analysis of 2023 paid claims data indicated that 43 out of the 92 codes on the Connecticut Independent Audiology and Speech and Language Pathology fee schedule had no utilization during calendar year (CY) 2023. Two codes accounted for approximately 81% of the total number of audiology and speech claims for CY 2023: procedure codes 92507 (treatment of speech, language, voice, communication, and/or auditory processing disorder) and 92526 (treatment of swallowing dysfunction and/or oral function for feeding). The Medicare comparison rate for these codes was, respectively, 42% and 61%.

The Physician Office and Outpatient Fee Schedule contains 84 of the same audiology and speech codes. Fees for those codes range from 63 percent to 100 percent of the therapy fees.

Chiropractor

Myers and Stauffer reviewed 4 codes and rates for Chiropractor services in the Connecticut Medicaid program, as shown in *Table 11*, and compared the rates to rates for Medicaid programs in the states of Maine, Massachusetts, New Jersey, and Oregon. Connecticut Medicaid rates for 3 codes were also compared to Medicare rates.

Table 11: Summary of Chiropractor Fee Comparisons

Summary of Chiropractor Fee Comparisons		
	CT compared to Five-State Average[14]	**CT compared to Medicare**
Comparison Rate Percentage Range	69.3% - 94.8%	51% - 53.4%
Average Comparison Rate Percentage	87.1%	52.2%
Count of Distinct Codes Analyzed	4	3
Count of Connecticut Codes per Fee Schedule	4	4
Percentage of CT Codes Below Comparison Rate	100.0%	100.0%
75 - 100% Below the Comparison Rate	75.0%	0.0%
50 - 74% Below the Comparison Rate	25.0%	100.0%
25 - 49% Below the Comparison Rate	0.0%	0.0%
0 - 24% Below the Comparison Rate	0.0%	0.0%
Percentage of CT Codes Above the Comparison Rate	0.0%	0.0%
1 - 24% Above the Comparison Rate	0.0%	0.0%
25 - 49% Above the Comparison Rate	0.0%	0.0%
50 - 74% Above the Comparison Rate	0.0%	0.0%
75 - 99% Above the Comparison Rate	0.0%	0.0%
100% and Above the Comparison Rate	0.0%	0.0%
Estimated Current Expenditures	$496,320	N/A
Amount Excluded (No Match or Outlier)	$0	N/A
Estimated Expenditures at Five-State Benchmark	$547,791	N/A
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	$51,471	N/A
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	10.4%	N/A
Estimated Current Expenditures	N/A	$463,275
Amount Excluded (No Match)	N/A	$33,044
Estimated Expenditures at Medicare Rate	N/A	$715,721
Difference Between Estimated Current Expenditures and Estimated Expenditures at Medicare Rate	N/A	$252,445

[14] The Medicaid program in New York does not cover services provided by chiropractors, so the Comparison Rate is based on 4 states.

Summary of Chiropractor Fee Comparisons		
	CT compared to Five-State Average[14]	CT compared to Medicare
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Medicare Rate	N/A	54.5%

Observations

Connecticut Medicaid rates are overall lower than the Five-State Average rate and the Medicare rates. Beginning October 2024, chiropractors were permitted to bill the *New Patient Evaluation and Management Visit* codes available under the Physician Office and Outpatient fee schedule and are reimbursed at the standard physician rate.

Clinic and Outpatient Hospital Behavioral Health

Myers and Stauffer reviewed 106 codes and rates for Clinic and Outpatient Behavioral Health in the Connecticut Medicaid program, as shown in *Table 12*, and compared the rates to rates for Medicaid programs in the states of Maine, Massachusetts, New Jersey, New York, and Oregon. Connecticut Medicaid rates for 95 codes were also compared to Medicare rates.

Table 12: Summary of Clinic and Outpatient Hospital Behavioral Health Fee Comparisons

Summary of Clinic and Outpatient BH Comparisons		
	CT compared to Five-State Average	CT compared to Medicare[15]
Comparison Rate Percentage Range	20.6% - 186.8%	53.7% - 327%
Average Comparison Rate Percentage	108.5%	97.3%
Count of Distinct Codes Analyzed	106	95
Count of Connecticut Codes per Fee Schedule	153	153
Percentage of CT Codes Below Comparison Rate	38.7%	57.9%
75 - 100% Below the Comparison Rate	21.7%	49.5%
50 - 74% Below the Comparison Rate	12.26%	8.4%
25 - 49% Below the Comparison Rate	3.8%	0.0%
0 - 24% Below the Comparison Rate	0.9%	0.0%
Percentage of CT Codes Above the Comparison Rate	61.3%	42.1%
1 - 24% Above the Comparison Rate	32.1%	37.9%
25 - 49% Above the Comparison Rate	19.8%	2.1%
50 - 74% Above the Comparison Rate	6.6%	0.0%
75 - 99% Above the Comparison Rate	2.8%	0.0%
100% and Above the Comparison Rate	0.0%	2.1%

[15] Medicare does not provide coverage for many of the services included within this category, including all codes associated with care planning and plan development.

Summary of Clinic and Outpatient BH Comparisons		
	CT compared to Five-State Average	CT compared to Medicare[15]
Estimated Current Expenditures	$75,707,609	N/A
Amount Excluded (No Match or Outlier)	$22,579,206	N/A
Estimated Expenditures at Five-State Benchmark	$90,885,109	N/A
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	$15,177,500	N/A
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	20.0%	N/A
Estimated Current Expenditures	N/A	$49,570,863
Amount Excluded (No Match)	N/A	$48,715,952
Estimated Expenditures at Medicare Rate	N/A	$51,569,044
Difference Between Estimated Current Expenditures and Estimated Expenditures at Medicare Rate	N/A	$1,998,181
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Medicare Rate	N/A	4.0%

Observations

Overall, the Connecticut rates compare favorably to the Five-State Average rate and to the Medicare rates, however, there is variation across specific codes. Code H2019, Therapeutic Behavioral Health, comprised 27 percent of the matched expenditures. Many of the codes on the Clinic and Outpatient Behavioral Health fee schedule also appear on the Connecticut Physician and Outpatient Fee Schedule; for those codes on both fee schedules, rates for the Clinic and Outpatient Behavioral Health codes range from 66% to 580% of the Physician and Outpatient Fee Schedule rate.

Clinic-Medical

Myers and Stauffer reviewed 87 codes and rates for Clinic-Medical in the Connecticut Medicaid program, as shown in *Table 13,* and compared the rates to rates for Medicaid programs in the states of Maine, Massachusetts, New Jersey, New York, and Oregon. Connecticut Medicaid rates for 50 codes were also compared to Medicare rates.

Table 13: Summary of Clinic-Medical Fee Comparisons

Summary of Clinic-Medical Comparisons		
	CT compared to Five-State Average	CT compared to Medicare
Comparison Rate Percentage Range	31.7% - 174.5%	19.8% - 222.8%
Average Comparison Rate Percentage	104.0%	75.9%
Count of Distinct Codes Analyzed	87	50
Count of Connecticut Codes per Fee Schedule	140	140

Summary of Clinic-Medical Comparisons		
	CT compared to Five-State Average	**CT compared to Medicare**
Percentage of CT Codes Below Comparison Rate	40.2%	96.0%
75 - 100% Below the Comparison Rate	27.6%	36.0%
50 - 74% Below the Comparison Rate	10.3%	54.0%
25 - 49% Below the Comparison Rate	2.3%	4.0%
0 - 24% Below the Comparison Rate	0.0%	2.0%
Percentage of CT Codes Above the Comparison Rate	59.8%	4.0%
1 - 24% Above the Comparison Rate	42.5%	2.0%
25 - 49% Above the Comparison Rate	12.6%	0.0%
50 - 74% Above the Comparison Rate	4.6%	0.0%
75 - 99% Above the Comparison Rate	0.0%	0.0%
100% and Above the Comparison Rate	0.0%	2.0%
Estimated Current Expenditures	$1,388,195	N/A
Amount Excluded (No Match or Outlier)	$60,721	N/A
Estimated Expenditures at Five-State Benchmark	$1,657,065	N/A
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	$268,870	N/A
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	19%	N/A
Estimated Current Expenditures	N/A	$1,253,222
Amount Excluded (No Match)	N/A	$195,694
Estimated Expenditures at Medicare Rate	N/A	$1,732,719
Difference Between Estimated Current Expenditures and Estimated Expenditures at Medicare Rate	N/A	$479,497
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Medicare Rate	N/A	38.3%

Observations

Connecticut Medicaid rates compare favorably to the Five-State Average rate generally; almost all of the Connecticut fees for clinic medical services are lower than the Medicare rates. Analysis of 2023 paid claims data indicated no utilization for 78 out of the 140 codes on the Clinic-Medical fee schedule during CY 2023. More than 70% of the total allowed amount for services on the Clinic-Medical fee schedule is attributed to evaluation and management visits or preventive services which also appear on the Physician and Outpatient fee schedule.

The majority of the services included in the Connecticut Clinic-Medical fee schedule are reported with CPT codes. Codes within the Connecticut Clinic-Medical fee schedule also appear on other Connecticut fee schedules. Fees for office visits codes 99202 through 99215 are 55% of Physician Obstetric (OBS)

rates, 94% of Physician Pediatric (PED) rates, and 139% of Physician Office and Outpatient rates. Fees for preventive visits codes are 139% of the rates on the Physician Office fee schedule.

Clinic- Rehab

Myers and Stauffer reviewed 103 codes and rates for Clinic-Rehab in the Connecticut Medicaid program, as shown in *Table 14*, and compared the rates to rates for Medicaid programs in the states of Maine, Massachusetts, New Jersey, New York, and Oregon. Connecticut Medicaid rates for 108 codes were also compared to Medicare rates.

Table 14: Summary of Clinic-Rehab Fee Comparisons

Summary of Clinic Rehab Fee Comparisons		
	CT compared to Five-State Average	**CT compared to Medicare**
Comparison Rate Percentage Range	62% - 215.9%	29.7% - 234.9%
Average Comparison Rate Percentage	135.3%	96.0%
Count of Distinct Codes Analyzed	103	108
Count of Connecticut Codes per Fee Schedule	126	126
Percentage of CT Codes Below Comparison Rate	14.6%	65.7%
75 - 100% Below the Comparison Rate	10.7%	45.4%
50 - 74% Below the Comparison Rate	3.9%	16.7%
25 - 49% Below the Comparison Rate	0.0%	3.7%
0 - 24% Below the Comparison Rate	0.0%	0.0%
Percentage of CT Codes Above the Comparison Rate	85.4%	34.3%
1 - 24% Above the Comparison Rate	16.5%	19.4%
25 - 49% Above the Comparison Rate	42.7%	10.2%
50 - 74% Above the Comparison Rate	12.6%	1.9%
75 - 99% Above the Comparison Rate	8.7%	0.0%
100% and Above the Comparison Rate	4.9%	2.8%
Estimated Current Expenditures	$14,014,719	N/A
Amount Excluded (No Match or Outlier)	$740,691	N/A
Estimated Expenditures at Five-State Benchmark	$14,033,005	N/A
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	$18,285	N/A
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	0.1%	N/A
Estimated Current Expenditures	N/A	$14,108,056
Amount Excluded (No Match)	N/A	$647,354
Estimated Expenditures at Medicare Rate	N/A	$14,325,485
Difference Between Estimated Current Expenditures and Estimated Expenditures at Medicare Rate	N/A	$217,428

Summary of Clinic Rehab Fee Comparisons		
	CT compared to Five-State Average	CT compared to Medicare
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Medicare Rate	N/A	1.5%

Observations

Connecticut Medicaid rates compare favorably to the Five-State Average rate and the Medicare rate in general. An analysis of the 2023 paid claims data indicates that five procedure codes accounted for approximately 80% of the total allowed amount in CY 2023. These five codes are 97110 (therapy procedure), 92507 (treatment of speech, language, voice, communication, and/or auditory processing disorder), 97112 (neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and or proprioception for sitting and/or standing activities), 97530 (therapeutic activities, direct one-on-one patient contact), and 97140 (manual therapy techniques). Rates for these five codes average 86.7% of the Medicare rate.

Dialysis

Myers and Stauffer reviewed 35 codes and rates for Dialysis in the Connecticut Medicaid program, as shown in *Table 15*, and compared the rates to rates for Medicaid programs in the states of Maine, Massachusetts, New Jersey, New York, and Oregon. Because Medicare pays for dialysis services on a patient-specific basis, based on the patient's case mix (individual characteristics) and adjusted by a number of provider-specific add-ons, Myers and Stauffer could not compare the Connecticut rates to Medicare.

Table 15: Summary of Dialysis Fee Comparisons

Summary of Dialysis Fee Comparisons	
	CT Compared to Five-State Average
Comparison Rate Percentage Range	86.8% - 166.7%
Average Comparison Rate Percentage	125.6%
Count of Distinct Codes Analyzed	35
Count of Connecticut Codes per Fee Schedule	37
Percentage of CT Codes Below Comparison Rate	5.7%
75 - 100% Below the Comparison Rate	5.7%
50 - 74% Below the Comparison Rate	0.0%
25 - 49% Below the Comparison Rate	0.0%
0 - 24% Below the Comparison Rate	0.0%
Percentage of CT Codes Above the Comparison Rate	94.3%

Summary of Dialysis Fee Comparisons	
	CT Compared to Five-State Average
1 - 24% Above the Comparison Rate	48.6%
25 - 49% Above the Comparison Rate	31.4%
50 - 74% Above the Comparison Rate	14.3%
75 - 99% Above the Comparison Rate	0.0%
100% and Above the Comparison Rate	0.0%
Estimated Current Expenditures	$693,598
Amount Excluded (No Match)	$10,058,803
Estimated expenditures at Five-State Benchmark	$693,598
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	$0
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	0.0%

Observations

Connecticut Medicaid rates compare favorably to the Five-State Average rate; rates for almost all codes exceed the comparison rate. Paid claims analysis indicated that was no utilization for 26 out of the 37 codes during CY 2023. One code, 90999 - Unlisted Dialysis Procedure, does not have a Medicare fee and is manually priced by all the comparison states with the exception of Maine. This code is excluded from the comparisons and the associated expenditures are included in the Amount Excluded (No Match) line in the table.

Durable Medical Equipment (DME)

For the review of codes for DME, the codes were divided into two categories: DME codes for which reimbursement is not limited based on the Cures Act, and DME codes where the Cures Act limits apply. Additionally, the codes and rates for MEDS-Misc in the Connecticut Medicaid program were incorporated into the DME comparison.

The Cures Act prohibits federal Medicaid reimbursement to states for certain DME expenditures that are, in the aggregate, in excess of what Medicare would have paid for such items, either through fee-for-service or Medicare's competitive bidding program.[16] Not all Medicaid expenditures for DME are subject to this provision; it applies only to those items of DME covered by a state's Medicaid program that are also covered by Medicare. Likewise, the Act does not limit federal matching payments for items of DME that are covered under the state Medicaid plan but for which payment is not allowed under the Medicare program.[17] The separate analysis of codes was necessary in the comparison of codes across

[16] Section 1903(i)(27) to the Social Security Act (the Act)
[17] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18001.pdf

Connecticut to make certain that the estimate of expenditures at the Five-State Average rate would be based on rates that did not exceed Cure Act limits.

The results of the two separate analyses are presented below. Myers and Stauffer reviewed 682 codes and rates to which the Cures Act does not apply, and 307 codes and rates to which the Cures Act limits apply. Codes and rates for Medicaid programs in the states of Maine, Massachusetts, New Jersey, New York, and Oregon were compared. Connecticut Medicaid codes and rates for 542 non-Cures Act and 230 Cures Act codes were also compared to Medicare rates.

Table 16 presents the analysis of codes that are not included in the Cures Act.

Table 16: Summary of DME Fee Comparisons (Non-Cures Act)

Summary of DME Fee Comparisons (Non-Cures Act)		
	CT compared to Five-State Average	**CT compared to Medicare**
Comparison Rate Percentage Range	45.8% - 120.6%	5.9% - 129.8%
Average Comparison Rate Percentage	83.5%	66.7%
Count of Distinct Codes Analyzed	683	542
Count of Connecticut Codes per Fee Schedule	1,257	1,257
Percentage of CT Codes Below Comparison Rate	91.2%	99.4%
75 - 100% Below the Comparison Rate	69.1%	19.0%
50 - 74% Below the Comparison Rate	20.6%	69.1%
25 - 49% Below the Comparison Rate	1.5%	10.5%
0 - 24% Below the Comparison Rate	0.0%	0.7%
Percentage of CT Codes Above the Comparison Rate	8.8%	0.6%
1 - 24% Above the Comparison Rate	8.8%	0.4%
25 - 49% Above the Comparison Rate	0.0%	0.2%
50 - 74% Above the Comparison Rate	0.0%	0.0%
75 - 99% Above the Comparison Rate	0.0%	0.0%
100% and Above the Comparison Rate	0.0%	0.0%
Estimated Current Expenditures	$621,590	N/A
Amount Excluded (No Match or Outlier)	$1,498,856	N/A
Estimated Expenditures at Five-State Benchmark	$659,999	N/A
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	$38,409	N/A
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	6.2%	N/A
Estimated Current Expenditures	N/A	$26,603
Amount Excluded (No Match)	N/A	$2,093,844
Estimated Expenditures at Medicare Rate	N/A	$31,126

Summary of DME Fee Comparisons (Non-Cures Act)		
	CT compared to Five-State Average	CT compared to Medicare
Difference Between Estimated Current Expenditures and Estimated Expenditures at Medicare Rate	N/A	$4,523
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Medicare Rate	N/A	17.0%

Table 17 presents the analysis of codes that are included in the Cures Act.

Table 17: Summary of DME Fee Comparisons (Cures Act)

Summary of DME Fee Comparisons (Cures Act)		
	CT compared to Five-State Average	CT compared to Medicare
Comparison Rate Percentage Range	44.3% - 127.7%	33.6% - 139.7%
Average Comparison Rate Percentage	85.9%	73.6%
Count of Distinct Codes Analyzed	307	230
Count of Connecticut Codes per Fee Schedule	381	381
Percentage of CT Codes Below Comparison Rate	81.8%	93.9%
75 - 100% Below the Comparison Rate	59.9%	32.2%
50 - 74% Below the Comparison Rate	18.6%	59.1%
25 - 49% Below the Comparison Rate	3.3%	2.6%
0 - 24% Below the Comparison Rate	0.0%	0.0%
Percentage of CT Codes Above the Comparison Rate	18.2%	6.1%
1 - 24% Above the Comparison Rate	17.9%	5.2%
25 - 49% Above the Comparison Rate	0.3%	0.9%
50 - 74% Above the Comparison Rate	0.0%	0.0%
75 - 99% Above the Comparison Rate	0.0%	0.0%
100% and Above the Comparison Rate	0.0%	0.0%
Estimated Current Expenditures	$20,453,117	N/A
Amount Excluded (No Match or Outlier)	$5,737,787	N/A
Estimated Expenditures at Five-State Benchmark	$25,786,591	N/A
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	$5,333,474	N/A
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	26.1%	N/A
Estimated Current Expenditures	N/A	$9,315,466
Amount Excluded (No Match)	N/A	$16,875,438
Estimated Expenditures at Medicare Rate	N/A	$11,307,759
Difference Between Estimated Current Expenditures and Estimated Expenditures at Medicare Rate	N/A	$1,992,293

Summary of DME Fee Comparisons (Cures Act)		
	CT compared to Five-State Average	CT compared to Medicare
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Medicare Rate	N/A	21.4%

Observations

To comply with the Cures Act, in April 2018 the rates for DME items affected/subject to federal law were set to 100% of the 2018 Medicare fee schedule.

Family Planning Clinic

Myers and Stauffer reviewed 130 codes and rates for Family Planning Clinics in the Connecticut Medicaid program, as shown in *Table 18*, and compared the rates to rates for Medicaid programs in the states of Maine, Massachusetts, New Jersey, New York, and Oregon. Connecticut Medicaid rates for 110 codes were also compared to Medicare rates.

Table 18: Summary of Family Planning Clinics Fee Comparisons

Summary of Family Planning Fee Comparisons		
	CT compared to Five-State Average	CT compared to Medicare
Comparison Rate Percentage Range	24.5% - 179.6%	36.3% - 357.1%
Average Comparison Rate Percentage	102.2%	95.9%
Count of Distinct Codes Analyzed	130	110
Count of Connecticut Codes per Fee Schedule	174	174
Percentage of CT Codes Below Comparison Rate	41.5%	70.9%
75 - 100% Below the Comparison Rate	22.3%	40.0%
50 - 74% Below the Comparison Rate	13.1%	27.3%
25 - 49% Below the Comparison Rate	5.4%	3.6%
0 - 24% Below the Comparison Rate	0.8%	0.0%
Percentage of CT Codes Above the Comparison Rate	58.5%	29.1%
1 - 24% Above the Comparison Rate	42.3%	13.6%
25 - 49% Above the Comparison Rate	6.9%	10.0%
50 - 74% Above the Comparison Rate	7.7%	3.6%
75 - 99% Above the Comparison Rate	1.5%	0.0%
100% and Above the Comparison Rate	0.0%	1.8%
Estimated Current Expenditures	$7,179,541	N/A
Amount Excluded (No Match or Outlier)	$833,420	N/A
Estimated Expenditures at Five-State Benchmark	$9,244,834	N/A

Summary of Family Planning Fee Comparisons		
	CT compared to Five-State Average	CT compared to Medicare
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	$2,065,293	N/A
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	28.8%	N/A
Estimated Current Expenditures	N/A	$3,994,561
Amount Excluded (No Match)	N/A	$4,018,400
Estimated Expenditures at Medicare Rate	N/A	$4,030,589
Difference Between Estimated Current Expenditures and Estimated Expenditures at Medicare Rate	N/A	$36,028
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Medicare Rate	N/A	0.9%

Observations

Connecticut Medicaid Family Planning Clinic rates compare favorably to the Five-State Average rate and the Medicare rate in general, but there is some variance in comparison rates across certain codes. Analysis of 2023 paid claims data indicated that there was no utilization for 81 out of the 174 codes on the fee schedule during CY 2023. Five procedure codes account for approximately 55% of the total allowed amount for Connecticut Family Planning Clinic services: S0199 (Medically Induced Abortion), 99213 (Evaluation and Management for an Established Patient), S4993 (Contraceptive Pills for Birth Control), 59840 (Dilation and Curettage), and J7307 (Etonogestral Contraceptive Implant System).

Fees on the Family Planning Clinic fee schedule also appear in other Connecticut fee schedules; fees for evaluation and management visit codes are 90% of the Physician Obstetric rate, 154% of the Physician Pediatric rate, and 198% of the Physician and Outpatient fee schedule rate. In comparison to the payments that Connecticut makes for physicians under the HUSKY A fee schedule, which are matched by the federal government at the rate of 50%, the federal match for Connecticut expenditures for family planning clinic services (and services paid under the HUSKY D fee schedule) is 90%.

Emergency Transportation

Myers and Stauffer grouped the Transportation - Air Ambulance, Transportation - Basic/Advanced, and Transportation - Critical Helicopter. These fee schedules were analyzed together as the rates generally appear on a single transportation fee schedule in the comparison states. A total of 12 codes and rates for Emergency Transportation in the Connecticut Medicaid program were reviewed, as shown in

Table 19*,* and compared to the rates for Medicaid programs in the states of Maine, Massachusetts, New Jersey, New York, and Oregon. Connecticut Medicaid rates for 9 codes were also compared to Medicare rates.

Table 19: Summary of Emergency Transportation Fee Comparisons

Summary of Emergency Transportation Fee Comparisons		
	CT compared to Five-State Average	**CT compared to Medicare**
Comparison Rate Percentage Range	43% - 188.1%	27.5% - 157.2%
Average Comparison Rate Percentage	94.4%	68.5%
Count of Distinct Codes Analyzed	12	9
Count of Connecticut Codes per Fee Schedule	15	15
Percentage of CT Codes Below Comparison Rate	50.0%	88.9%
75 - 100% Below the Comparison Rate	25.0%	0.0%
50 - 74% Below the Comparison Rate	0.0%	77.8%
25 - 49% Below the Comparison Rate	25.0%	11.1%
0 - 24% Below the Comparison Rate	0.0%	0.0%
Percentage of CT Codes Above the Comparison Rate	50.0%	11.1%
1 - 24% Above the Comparison Rate	25.0%	0.0%
25 - 49% Above the Comparison Rate	16.7%	0.0%
50 - 74% Above the Comparison Rate	0.0%	11.1%
75 - 99% Above the Comparison Rate	8.3%	0.0%
100% and Above the Comparison Rate	0.0%	0.0%
Estimated Current Expenditures	$50,561,414	N/A
Amount Excluded (No Match or Outlier)	$688,920	N/A
Estimated Expenditures at Five-State Benchmark	$53,379,029	N/A
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	$2,817,615	N/A
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	5.6%	N/A
Estimated Current Expenditures	N/A	$51,168,697
Amount Excluded (No Match)	N/A	$81,637
Estimated Expenditures at Medicare Rate	N/A	$67,048,480
Difference Between Estimated Current Expenditures and Estimated Expenditures at Medicare Rate	N/A	$15,879,782
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Medicare Rate	N/A	31.0%

Observations

Connecticut Medicaid Emergency Transportation rates in general compare favorably to the Five-State Average rates; however, there is variability in the comparison rates by code: half of the codes are below the rate and half are above. While there is some inconsistency in comparison rates across individual

codes, the fees for the higher utilized codes related to ambulance and mileage are generally low in comparison to Medicare's fees.[18]

Home Health

The fee schedule for Home Health in the Connecticut Medicaid program includes rates for both procedure codes and revenue codes for home health services. For example, most of the therapy visits are billed using revenue codes, while the nursing and nurse aide visits are billed using a combination of revenue codes, procedure codes, and modifiers to identify the nursing level, time spent with the patient, units, and other factors. Of the comparison states, Massachusetts uses only HCPCS codes. New Jersey and New York (pediatric home health) use revenue code/service descriptions. New York's adult home health services are paid based on episodes of care payment, modeled after Medicare's approach. Oregon's home health fee schedule contains revenue codes, and four nursing HCPCS codes that appear to align with Connecticut's Home Health procedure codes.

The comparison of rates is divided into two sections to reflect these different code sets. For procedure codes, an analysis comparable to the analyses conducted for other services was conducted. Because revenue codes report services more generally than HCPCS codes, rates for those codes were compared using the alternative approach (i.e., minimum, median, and max rates for comparison states were compared to Connecticut's rates). This approach was necessary because two of the comparison states – New Jersey and New York – have provider-specific rates that were originally based on costs and are not comparable to those used by Connecticut.

Myers and Stauffer reviewed four procedure codes and rates for Home Health in the Connecticut Medicaid program, as shown in *Table 20*, and compared the rates to rates for Medicaid programs in the states of Maine, Massachusetts, and Oregon. Thirty-eight codes could not be compared to the comparison states because Connecticut uses codes and modifiers that are not used by the comparison states.

Table 20: Home Health Procedure Code Fee Comparisons

Summary of Home Health Procedure Code Fee Comparisons	
	CT Compared to Five-State Average
Comparison Rate Percentage Range	79.9% - 116.5%
Average Comparison Rate Percentage	98.2%
Count of Distinct Codes Analyzed	4
Count of Connecticut Codes per Fee Schedule	42
Percentage of CT Codes Below Comparison Rate	50.0%

[18] Rates included in the analysis were in effect as of 1/1/24 and do not include the subsequent rate increase from 7/1/24.

Summary of Home Health Procedure Code Fee Comparisons	
	CT Compared to Five-State Average
75 - 100% Below the Comparison Rate	50.0%
50 - 74% Below the Comparison Rate	0.0%
25 - 49% Below the Comparison Rate	0.0%
0 - 24% Below the Comparison Rate	0.0%
Percentage of CT Codes Above the Comparison Rate	50.0%
1 - 24% Above the Comparison Rate	50.0%
25 - 49% Above the Comparison Rate	0.0%
50 - 74% Above the Comparison Rate	0.0%
75 - 99% Above the Comparison Rate	0.0%
100% and Above the Comparison Rate	0.0%
Estimated Current Expenditures	$32,063,041
Amount Excluded (No Match or Outlier)	$155,428,382
Estimated expenditures at Five-State Benchmark	$50,080,567
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	$18,017,526
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	56.2%

Myers and Stauffer reviewed 6 revenue codes rates for Home Health in the Connecticut Medicaid program, as shown in *Table 21*, and compared the rates to rates for Medicaid programs in the states of New Jersey, New York, and Oregon. As with all of the codes where a range of comparisons are modeled, expenditure and volume data are not included in the table.

Table 21: Home Health Revenue Code Fee Comparisons

Comparison of Home Health Revenue Code Rates (% Relative to Connecticut)										
		CT	**NJ**		**NY**		**OR**		**Average of Comparison States**	
Rev Code	**Rate Statistic**	**Rate**	**Rate**	**CT rate as a percent of comparison rate**	**Rate**	**CT rate as a percent of comparison rate**	**Rate**	**CT rate as a percent of comparison rate**	**Rate**	**CT rate as a percent of comparison rate**
421	Min	$84.14	$19.50	431.5%	$82.19	102.4%	$153.21	54.9%	$84.97	99.0%
421	Median	$84.14	$62.42	134.8%	$134.65	62.5%	$153.21	54.9%	$116.76	72.1%
421	Max	$84.14	$103.97	80.9%	$185.42	45.4%	$153.21	54.9%	$147.53	57.0%
421	Average	$84.14	$61.54	136.7%	$137.08	61.4%	$153.21	54.9%	$117.28	71.7%
424	Min	$84.14	$19.50	431.5%	$82.19	102.4%	$153.21	54.9%	$84.97	99.0%
424	Median	$84.14	$62.42	134.8%	$134.65	62.5%	$153.21	54.9%	$116.76	72.1%
424	Max	$84.14	$103.97	80.9%	$185.42	45.4%	$153.21	54.9%	$147.53	57.0%

Comparison of Home Health Revenue Code Rates (% Relative to Connecticut)										
		CT	NJ		NY		OR		Average of Comparison States	
Rev Code	Rate Statistic	Rate	Rate	CT rate as a percent of comparison rate	Rate	CT rate as a percent of comparison rate	Rate	CT rate as a percent of comparison rate	Rate	CT rate as a percent of comparison rate
424	Average	$84.14	$61.54	136.7%	$137.08	61.4%	$153.21	54.9%	$117.28	71.7%
431	Min	$86.58	$12.37	699.9%	$89.14	97.1%	$157.91	54.8%	$86.47	100.1%
431	Median	$86.58	$59.78	144.8%	$136.40	63.5%	$157.91	54.8%	$118.03	73.4%
431	Max	$86.58	$94.90	91.2%	$228.20	37.9%	$157.91	54.8%	$160.34	54.0%
431	Average	$86.58	$57.61	150.3%	$140.16	61.8%	$157.91	54.8%	$118.56	73.0%
434	Min	$86.58	$12.37	699.9%	$89.14	97.1%	$157.91	54.8%	$86.47	100.1%
434	Median	$86.58	$59.78	144.8%	$136.40	63.5%	$157.91	54.8%	$118.03	73.4%
434	Max	$86.58	$94.90	91.2%	$228.20	37.9%	$157.91	54.8%	$160.34	54.0%
434	Average	$86.58	$57.61	150.3%	$140.16	61.8%	$157.91	54.8%	$118.56	73.0%
441	Min	$86.58	$28.84	300.2%	$35.16	246.2%	$172.48	50.2%	$78.83	109.8%
441	Median	$86.58	$54.80	158.0%	$131.09	66.0%	$172.48	50.2%	$119.46	72.5%
441	Max	$86.58	$224.86	38.5%	$204.25	42.4%	$172.48	50.2%	$200.53	43.2%
441	Average	$86.58	$65.44	132.3%	$128.04	67.6%	$172.48	50.2%	$121.99	71.0%
444	Min	$86.58	$28.84	300.2%	$35.16	246.2%	$172.48	50.2%	$78.83	109.8%
444	Median	$86.58	$54.80	158.0%	$131.09	66.0%	$172.48	50.2%	$119.46	72.5%
444	Max	$86.58	$224.86	38.5%	$204.25	42.4%	$172.48	50.2%	$200.53	43.2%
444	Average	$86.58	$65.44	132.3%	$128.04	67.6%	$172.48	50.2%	$121.99	71.0%

Observations

Connecticut Medicaid Home Health rates that are reported with procedure codes compare favorably to the Five-State Average rate; half of the fees are below the comparison rate and half are more than the comparison rate for 4 codes.

For services reported with revenue codes, comparison was limited. For the Home Health revenue code rates, Connecticut and Oregon both have statewide rates. The Home Health revenue code rates for both New Jersey and New York are provider specific. Further, the New York rates are pediatric rates; rates for adults are comparable to the Medicare approach and are based on 60-day episodes of care. Where comparisons were possible, Connecticut Medicaid rates are generally lower than the comparison rates for median, max and average comparison rates.

Almost 52 percent of the expenditures for CY 2023 (approximately $96 million of the total $187 million) related to the Home Health fee schedule are associated with procedure code T1502 (administration of oral, intramuscular and/or subcutaneous medication by health care agency/professional) and T1503 (administration of medication other than oral and/or injectable, by a health care agency/professional). Discussions with DSS staff indicate that although the two codes are included in the Home Health fee

schedule, they are predominantly used for behavioral health medication management. Currently the service described for these codes provides support to individuals with behavioral health conditions including identifying indications of crisis and ensuring compliance with medication. These codes are not used for this purpose or population in the comparison states so Myers and Stauffer did not compare the fees for these codes.

Independent Radiology

Myers and Stauffer reviewed 1,491 codes and rates for Independent Radiology in the Connecticut Medicaid program, as shown in *Table 22*, and compared the rates to rates for Medicaid programs in the states of Maine, Massachusetts, New Jersey, New York, and Oregon. Connecticut Medicaid rates for 1,567 codes were also compared to Medicare rates.

Table 22: Summary of Independent Radiology Fee Comparisons

Summary of Independent Radiology Fee Comparisons		
	CT compared to Five-State Average	**CT compared to Medicare**
Comparison Rate Percentage Range	36.3% - 202.7%	2.8% - 647.8%
Average Comparison Rate Percentage	112.5%	80.0%
Count of Distinct Codes Analyzed	1,491	1,567
Count of Connecticut Codes per Fee Schedule	1,711	1,711
Percentage of CT Codes Below the Comparison Rate	36.5%	81.6%
75 - 100% Below the Comparison Rate	31.5%	8.9%
50 - 74% Below the Comparison Rate	4.4%	57.3%
25 - 49% Below the Comparison Rate	0.5%	14.5%
0 - 24% Below the Comparison Rate	0.0%	1.0%
Percentage of CT Codes Above the Comparison Rate	63.5%	18.4%
101 - 124% Above the Comparison Rate	38.4%	7.3%
125 - 149% Above the Comparison Rate	12.6%	4.7%
150 - 174% Above the Comparison Rate	8.5%	1.2%
175 - 199% Above the Comparison Rate	3.7%	1.0%
200% and Above the Comparison Rate	0.3%	4.1%
Estimated Current Expenditures	$1,326,599	N/A
Amount Excluded (No Match or Outlier)	$352,643	N/A
Estimated Expenditures at Five-State Benchmark	$1,339,397	N/A
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	$12,798	N/A
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	1.0%	N/A
Estimated Current Expenditures	N/A	$973,834

Summary of Independent Radiology Fee Comparisons		
	CT compared to Five-State Average	CT compared to Medicare
Amount Excluded (No Match)	N/A	$705,408
Estimated Expenditures at Medicare Rate	N/A	$1,085,625
Difference Between Estimated Current Expenditures and Estimated Expenditures at Medicare Rate	N/A	$111,791
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Medicare Rate	N/A	11.5%

Observations

Connecticut Medicaid Independent Radiology rates overall compare favorably to the Five-State Average rates, however, Connecticut rates are generally lower than Medicare rates. Similar to other fee schedules, procedure codes on the Independent Radiology fee schedule are also included in the Physician Office and Outpatient and the Physician Radiology fee schedules. Fees for radiology services ranged from 14% to 721% of the Physician Office and Outpatient fee schedule and from 37% to 145% of the Physician Radiology Fee Schedule.

Laboratory

Myers and Stauffer reviewed 1,473 codes and rates for Laboratory Services in the Connecticut Medicaid program, as shown in *Table 23*, and compared the rates to rates for Medicaid programs in the states of Maine, Massachusetts, New Jersey, New York, and Oregon. Connecticut Medicaid rates for 1,598 codes were also compared to Medicare rates.

Table 23: Summary of Laboratory Fee Comparisons

Summary Laboratory Services Fee Comparisons		
	CT compared to Five-State Average	CT compared to Medicare
Comparison Rate Percentage Range	48.9% - 152.8%	5% - 214.8%
Average Comparison Rate Percentage	102.2%	77.8%
Count of Distinct Codes Analyzed	1,473	1,598
Count of Connecticut Codes per Fee Schedule	1,651	1,651
Percentage of CT Codes Below Comparison Rate	41.4%	99.4%
75 - 100% Below the Comparison Rate	32.1%	58.9%
50 - 74% Below the Comparison Rate	8.9%	26.2%
25 - 49% Below the Comparison Rate	0.4%	9.4%
0 - 24% Below the Comparison Rate	0.0%	4.8%
Percentage of CT Codes Above the Comparison Rate	58.6%	0.6%
1 - 24% Above the Comparison Rate	49.2%	0.3%

Summary Laboratory Services Fee Comparisons		
	CT compared to Five-State Average	CT compared to Medicare
25 - 49% Above the Comparison Rate	9.4%	0.1%
50 - 74% Above the Comparison Rate	0.1%	0.0%
75 - 99% Above the Comparison Rate	0.0%	0.1%
100% and Above the Comparison Rate	0.0%	0.1%
Estimated Current Expenditures	$50,011,861	N/A
Amount Excluded (No Match or Outlier)	$5,317,947	N/A
Estimated Expenditures at Five-State Benchmark	$51,900,599	N/A
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	$1,888,738	N/A
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	3.8%	N/A
Estimated Current Expenditures	N/A	$54,679,304
Amount Excluded (No Match)	N/A	$650,504
Estimated Expenditures at Medicare Rate	N/A	$66,122,138
Difference Between Estimated Current Expenditures and Estimated Expenditures at Medicare Rate	N/A	$11,442,834
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Medicare Rate	N/A	20.9%

Observations

Connecticut Medicaid laboratory fees overall compare favorably to the Five-State Average rates, but there is some variance in comparison rates across certain codes. Laboratory fees are also listed on the Physician Office and Outpatient Services, the Physician Radiology, and the Physician Surgical fee schedules. Comparison rates for services listed on the Physician Office and Outpatient Services fee schedule ranged from 9% to 304% for the codes that matched, rates for services listed on the Radiology Services fee schedule were 127% of the comparison rate for the codes that matched, and rates that were on the Physician Surgical fee schedule were 61% of the comparison rate for the codes that matched.

Connecticut rates are generally lower than Medicare rates. While 41.4% of the rates for codes are below the comparison state average, almost all of the rates for codes are below the Medicare average.

Medical Surgical Supplies

Similar to the analysis of DME codes, a separate analysis for the Cures Act/non-Cures Act codes was also necessary for the review of Medical Surgical Supplies.

Myers and Stauffer reviewed 171 codes and rates to which the Cures Act does not apply, and 229 codes and rates which are affected by the Cures Act limits. Codes and rates for Medicaid programs in the

states of Maine, Massachusetts, New Jersey, New York, and Oregon were compared. Connecticut Medicaid codes and rates for 163 non-Cures Act and 227 Cures Act codes were also compared to Medicare rates. *Table 24* presents the analysis of the non-Cures Act codes.

Table 24: Summary of Medical Surgical Supplies Fee Comparisons (Non-Cures Act)

Summary of Medical Surgical Supplies Fee Comparisons (Non-Cures Act)		
	CT compared to Five-State Average	**CT compared to Medicare**
Comparison Rate Percentage Range	70.9% - 119.7%	29.4% - 145.4%
Average Comparison Rate Percentage	90.1%	75.5%
Count of Distinct Codes Analyzed	171	163
Count of Connecticut Codes per Fee Schedule	234	234
Percentage of CT Codes Below Comparison Rate	85.4%	96.3%
75 - 100% Below the Comparison Rate	83.0%	43.6%
50 - 74% Below the Comparison Rate	2.3%	51.5%
25 - 49% Below the Comparison Rate	0.0%	1.2%
0 - 24% Below the Comparison Rate	0.0%	0.0%
Percentage of CT Codes Above the Comparison Rate	14.6%	3.7%
1 - 24% Above the Comparison Rate	14.6%	1.8%
25 - 49% Above the Comparison Rate	0.0%	1.8%
50 - 74% Above the Comparison Rate	0.0%	0.0%
75 - 99% Above the Comparison Rate	0.0%	0.0%
100% and Above the Comparison Rate	0.0%	0.0%
Estimated Current Expenditures	$11,228,580	N/A
Amount Excluded (No Match or Outlier)	$12,907,973	N/A
Estimated Expenditures at Five-State Benchmark	$12,080,633	N/A
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	$852,053	N/A
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	7.6%	N/A
Estimated Current Expenditures	N/A	$3,392
Amount Excluded (No Match)	N/A	$24,133,160
Estimated Expenditures at Medicare Rate	N/A	$3,925
Difference Between Estimated Current Expenditures and Estimated Expenditures at Medicare Rate	N/A	$533
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Medicare Rate	N/A	15.7%

Table 25 presents the analysis of codes included in the Cures Act.

Table 25: Summary of Medical Surgical Supplies Fee Comparisons (Cures Act)

Summary of Medical Surgical Supplies Fee Comparisons (Cures Act)		
	CT compared to Five-State Average	**CT compared to Medicare**
Comparison Rate Percentage Range	62.8% - 136.1%	38.1% - 723.6%
Average Comparison Rate Percentage	106.2%	71.7%
Count of Distinct Codes Analyzed	229	227
Count of Connecticut Codes per Fee Schedule	274	274
Percentage of CT Codes Below Comparison Rate	67.7%	96.0%
75 - 100% Below the Comparison Rate	62.9%	9.3%
50 - 74% Below the Comparison Rate	4.8%	85.9%
25 - 49% Below the Comparison Rate	0.0%	0.9%
0 - 24% Below the Comparison Rate	0.0%	0.0%
Percentage of CT Codes Above the Comparison Rate	32.3%	4.0%
1 - 24% Above the Comparison Rate	27.1%	0.4%
25 - 49% Above the Comparison Rate	5.2%	1.3%
50 - 74% Above the Comparison Rate	0.0%	0.9%
75 - 99% Above the Comparison Rate	0.0%	0.4%
100% and Above the Comparison Rate	0.0%	0.9%
Estimated Current Expenditures	$13,557,285	N/A
Amount Excluded (No Match or Outlier)	$2,015,815	N/A
Estimated Expenditures at Five-State Benchmark	$15,166,384	N/A
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	$1,609,100	N/A
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	11.9%	N/A
Estimated Current Expenditures	N/A	$3,477
Amount Excluded (No Match)	N/A	$1,401,614
Estimated Expenditures at Medicare Rate	N/A	$4,250
Difference Between Estimated Current Expenditures and Estimated Expenditures at Medicare Rate	N/A	$773
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Medicare Rate	N/A	22.2%

Observations

Connecticut Medical Surgical Supplies (Cures Act) fees overall compare favorably to the Five-State Average rates, but there is some variance in comparison rates across certain codes. Connecticut rates are generally lower than Medicare rates. For non-Cures Act codes, overall fees are lower than both the

Five-State Average rates and the Medicare rates. There is a broad range of variation in the fee comparison percentages for this group.

MEDS-Enteral/Parenteral

Similar to the analysis of DME codes, a separate analysis for the Cures Act/non-Cures Act codes was also necessary for the review of MEDS-Enteral/Parenteral services.

There was no utilization for non-Cures Act codes. Myers and Stauffer reviewed 11 Cures Act codes and rates for MEDS-Enteral/Parenteral services in the Connecticut Medicaid program and compared the rates to rates for Medicaid programs in the states of Maine, Massachusetts, New Jersey, New York, and Oregon. Connecticut Medicaid rates for 11 Cures Act codes were also compared to Medicare rates.

Table 26 presents the analysis of Cures Act codes.

Table 26: Summary of Meds-Enteral/Parenteral Fee Comparisons (Cures Act)

Summary of MEDS-Enteral/Parenteral Fee Comparisons (Cures Act)		
	CT compared to Five-State Average	**CT compared to Medicare**
Comparison Rate Percentage Range	12.6% - 126.8%	60.7% - 116.9%
Average Comparison Rate Percentage	61.4%	92.4%
Count of Distinct Codes Analyzed	11	11
Count of Connecticut Codes per Fee Schedule	12	12
Percentage of CT Codes Below Comparison Rate	54.5%	54.5%
75 - 100% Below the Comparison Rate	0.0%	27.3%
50 - 74% Below the Comparison Rate	0.0%	27.3%
25 - 49% Below the Comparison Rate	9.1%	0.0%
0 - 24% Below the Comparison Rate	45.5%	0.0%
Percentage of CT Codes Above the Comparison Rate	45.5%	45.5%
1 - 24% Above the Comparison Rate	36.4%	45.5%
25 - 49% Above the Comparison Rate	9.1%	0.0%
50 - 74% Above the Comparison Rate	0.0%	0.0%
75 - 99% Above the Comparison Rate	0.0%	0.0%
100% and Above the Comparison Rate	0.0%	0.0%
Estimated Current Expenditures	$2,770,234	N/A
Amount Excluded (No Match or Outlier)	$62,762	N/A
Estimated Expenditures at Five-State Benchmark	$17,115,531	N/A
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	$14,345,297	N/A
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	517.8%	N/A

Summary of MEDS-Enteral/Parenteral Fee Comparisons (Cures Act)		
	CT compared to Five-State Average	CT compared to Medicare
Estimated Current Expenditures	N/A	$2,770,234
Amount Excluded (No Match)	N/A	$62,762
Estimated Expenditures at Medicare Rate	N/A	$2,877,641
Difference Between Estimated Current Expenditures and Estimated Expenditures at Medicare Rate	N/A	$107,407
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Medicare Rate	N/A	3.9%

Observations

Rates for codes limited by the Cures Act were generally comparable to Medicare rates, with only a 3.9% difference in expenditures based on the Medicare comparison. However, rates were overall lower for the Five-State Average rate comparison, many significantly below the comparison rate, with 45.5% of rates for codes in the 0 -24% comparison range.

MEDS -Hearing Aid and Prosthetic Eye

Myers and Stauffer reviewed 27 codes and rates for Hearing Aid and Prosthetic Eye in the Connecticut Medicaid program, as shown in *Table 27*, and compared the rates to rates for Medicaid programs in the states of Maine, Massachusetts, New Jersey, New York, and Oregon. Connecticut Medicaid rates for 6 codes were also compared to Medicare rates. None of the codes in this fee schedule are affected by the Cures Act limits.

Table 27: Summary of MEDS - Hearing Aid and Prosthetic Eye Fee Comparisons

Summary of Hearing Aid and Prosthetic Eye Comparisons		
	CT compared to Five-State Average	CT compared to Medicare[19]
Comparison Rate Percentage Range	15.7% - 123.1%	67.7% - 71.4%
Average Comparison Rate Percentage	74.4%	70.8%
Count of Distinct Codes Analyzed	27	6
Count of Connecticut Codes per Fee Schedule	71	71
Percentage of CT Codes Below Comparison Rate	81.5%	100.0%
75 - 100% Below the Comparison Rate	18.5%	0.0%
50 - 74% Below the Comparison Rate	51.9%	100.0%
25 - 49% Below the Comparison Rate	3.7%	0.0%
0 - 24% Below the Comparison Rate	7.4%	0.0%

[19] Medicare does not provide coverage for hearing aids. Only the codes associate with prosthetic eyes were matched for the comparison.

Summary of Hearing Aid and Prosthetic Eye Comparisons		
	CT compared to Five-State Average	**CT compared to Medicare[19]**
Percentage of CT Codes Above the Comparison Rate	18.5%	0.0%
1 - 24% Above the Comparison Rate	18.5%	0.0%
25 - 49% Above the Comparison Rate	0.0%	0.0%
50 - 74% Above the Comparison Rate	0.0%	0.0%
75 - 99% Above the Comparison Rate	0.0%	0.0%
100% and Above the Comparison Rate	0.0%	0.0%
Estimated Current Expenditures	$1,514,623	N/A
Amount Excluded (No Match or Outlier)	$947,824	N/A
Estimated Expenditures at Five-State Benchmark	$3,135,422	N/A
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	$1,620,799	N/A
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	107.0%	N/A
Estimated Current Expenditures	N/A	$83,440
Amount Excluded (No Match)	N/A	$2,379,007
Estimated Expenditures at Medicare Rate	N/A	$94,718
Difference Between Estimated Current Expenditures and Estimated Expenditures at Medicare Rate	N/A	$11,278
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Medicare Rate	N/A	13.5%

Observations

Connecticut Medicaid rates are overall lower than the Five-State Comparison rates and the Medicare rates. A review of paid claims data for 2023 indicates that there was no utilization of 35 out of the 71 codes on the Connecticut MEDS-Hearing Aid and Prosthetic Eye fee schedule during CY 2023. Procedure codes V5140 (binaural, behind the ear) and V5160 (dispensing fee, binaural) accounted for approximately 65% of the total allowed amount for CY 2023 claims. Most of the procedure codes with utilization were billed with modifier RB (replacement of part).

MEDS-Prosthetic/Orthotic

Myers and Stauffer reviewed 638 codes and rates for MEDS-Prosthetic/Orthotic in the Connecticut Medicaid program, as shown in *Table* 28, and compared the rates to rates for Medicaid programs in the states of Maine, Massachusetts, New Jersey, New York, and Oregon. Connecticut Medicaid rates for 787 codes were also compared to Medicare rates. None of the codes in this fee schedule are affected by the Cures Act limits.

Table 28: Summary of MEDS-Prosthetic/Orthotic Fee Comparisons

Summary of MEDS-Prosthetic/Orthotic Fee Comparisons		
	CT compared to Five-State Average	**CT compared to Medicare**
Comparison Rate Percentage Range	61.8% - 83.9%	36% - 113%
Average Comparison Rate Percentage	74.3%	61.9%
Count of Distinct Codes Analyzed	638	787
Count of Connecticut Codes per Fee Schedule	1,171	1,171
Percentage of CT Codes Below Comparison Rate	100.0%	99.9%
75 - 100% Below the Comparison Rate	50.5%	2.8%
50 - 74% Below the Comparison Rate	49.5%	96.3%
25 - 49% Below the Comparison Rate	0.0%	0.8%
0 - 24% Below the Comparison Rate	0.0%	0.0%
Percentage of CT Codes Above the Comparison Rate	0.0%	0.1%
1 - 24% Above the Comparison Rate	0.0%	0.1%
25 - 49% Above the Comparison Rate	0.0%	0.0%
50 - 74% Above the Comparison Rate	0.0%	0.0%
75 - 99% Above the Comparison Rate	0.0%	0.0%
100% and Above the Comparison Rate	0.0%	0.0%
Estimated Current Expenditures	$9,608,409	N/A
Amount Excluded (No Match or Outlier)	$2,442,005	N/A
Estimated Expenditures at Five-State Benchmark	$13,013,914	N/A
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	$3,405,505	N/A
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	35.4%	N/A
Estimated Current Expenditures	N/A	$11,374,116
Amount Excluded (No Match)	N/A	$676,298
Estimated Expenditures at Medicare Rate	N/A	$15,222,896
Difference Between Estimated Current Expenditures and Estimated Expenditures at Medicare Rate	N/A	$3,848,780
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Medicare Rate	N/A	33.8%

Observations

Connecticut Medicaid rates are overall lower than the Five-State Average rates and the Medicare rates. An analysis of the 2023 claims data indicates that there was no utilization for 733 out of the 1,171 codes on the Connecticut MEDS-Prosthetic/Orthotic fee schedule.

Naturopath

Myers and Stauffer reviewed 9 codes and rates for Naturopath services in the Connecticut Medicaid program, as shown in *Table 29*, and compared the rates to rates for Medicaid programs in the states of Maine and Oregon. Medicaid programs in Massachusetts, New Jersey, and New York do not cover the services of naturopaths. Medicare also does not cover these services.

Table 29: Summary of Naturopath Fee Comparisons

Summary of Naturopath Fee Comparison	
	CT compared to Comparison State Average
Comparison Rate Percentage Range	59.6% - 81.1%
Average Comparison Rate Percentage	69.7%
Count of Distinct Codes Analyzed	9
Count of Connecticut Codes per Fee Schedule	10
Percentage of CT Codes Below Comparison Rate	100.0%
75 - 100% Below the Comparison Rate	44.4%
50 - 74% Below the Comparison Rate	55.6%
25 - 49% Below the Comparison Rate	0.0%
0 - 24% Below the Comparison Rate	0.0%
Percentage of CT Codes Above the Comparison Rate	0.0%
1 - 24% Above the Comparison Rate	0.0%
25 - 49% Above the Comparison Rate	0.0%
50 - 74% Above the Comparison Rate	0.0%
75 - 99% Above the Comparison Rate	0.0%
100% and Above the Comparison Rate	0.0%
Estimated Current Expenditures	$748,901
Amount Excluded (No Match)	$0
Estimated expenditures at Five-State Benchmark	$1,154,385
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	$405,484
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	54.1%

Observations

Connecticut Medicaid rates are overall lower than the Five-State Average rates. The procedure codes listed on the Naturopath fee schedule are all evaluation and management visit codes. Naturopath codes are also included in other fee schedules; naturopath rates are 41% of rates on the Physician Office and

Outpatient fee schedule (Obstetric rate) schedule, 70% of rates on the Physician Office and Outpatient fee schedule (Pediatric rate), and 90% of rates on the Physician Office and Outpatient fee schedule.

Optician and Eyeglasses

Myers and Stauffer reviewed 83 codes and rates for Optician/Eyeglasses in the Connecticut Medicaid program, as shown in *Table 30*, and compared the rates to rates for Medicaid programs in the states of Maine, Massachusetts, New Jersey, New York, and Oregon. Connecticut Medicaid rates for 77 codes were also compared to Medicare rates.

Table 30: Summary of Optician and Eyeglass Fee Comparisons

Summary of Optician and Eyeglass Fee Comparisons		
	CT compared to Five-State Average	**CT compared to Medicare**
Comparison Rate Percentage Range	27.9% - 170.9%	11.8% - 103.3%
Average Comparison Rate Percentage	97.3%	45.1%
Count of Distinct Codes Analyzed	83	77
Count of Connecticut Codes per Fee Schedule	91	91
Percentage of CT Codes Below Comparison Rate	48.2%	98.7%
75 - 100% Below the Comparison Rate	22.9%	3.9%
50 - 74% Below the Comparison Rate	18.1%	16.9%
25 - 49% Below the Comparison Rate	7.2%	75.3%
0 - 24% Below the Comparison Rate	0.0%	2.6%
Percentage of CT Codes Above the Comparison Rate	51.8%	1.3%
1 - 24% Above the Comparison Rate	33.7%	1.3%
25 - 49% Above the Comparison Rate	15.7%	0.0%
50 - 74% Above the Comparison Rate	2.4%	0.0%
75 - 99% Above the Comparison Rate	0.0%	0.0%
100% and Above the Comparison Rate	0.0%	0.0%
Estimated Current Expenditures	$3,073,158	N/A
Amount Excluded (No Match or Outlier)	$662,678	N/A
Estimated Expenditures at Five-State Benchmark	$3,867,670	N/A
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	$794,513	N/A
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	26.9%	N/A
Estimated Current Expenditures	N/A	$2,345,614
Amount Excluded (No Match)	N/A	$1,390,222
Estimated Expenditures at Medicare Rate	N/A	$4,815,089
Difference Between Estimated Current Expenditures and Estimated Expenditures at Medicare Rate	N/A	$2,469,476

Summary of Optician and Eyeglass Fee Comparisons		
	CT compared to Five-State Average	CT compared to Medicare
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Medicare Rate	N/A	105.3%

Observations

Connecticut Medicaid rates overall compare favorably to the Five-State Average rates, although there is variation in the comparison rate percentages. Connecticut Medicaid rates are generally lower than the Medicare rates. Analysis of the claims data indicates that there was no utilization for 22 out of the 91 codes on the Optician and Eyeglasses fee schedule during CY 2023. The procedure codes V2020 (frames, purchases), V2103 (vision services, single vision), S0580 (polycarbonate lens), and 92340 (spectacle services) accounted for approximately 72% of the total allowed amount during CY 2023.

Physical and Occupational Therapy

Myers and Stauffer reviewed 64 codes and rates for Physical and Occupational Therapy in the Connecticut Medicaid program, as shown in *Table 31*, and compared the rates to rates for Medicaid programs in the states of Maine, Massachusetts, New Jersey, New York, and Oregon. Connecticut Medicaid rates for 66 codes were also compared to Medicare rates.

Table 31: Summary of Physical and Occupational Therapy Fee Comparisons

Summary of Physical and Occupational Therapy Fee Comparisons		
	CT compared to Five-State Average	CT compared to Medicare
Comparison Rate Percentage Range	49.1% - 161.6%	32.9% - 130.1%
Average Comparison Rate Percentage	92.3%	59.8%
Count of Distinct Codes Analyzed	64	66
Count of Connecticut Codes per Fee Schedule	74	74
Percentage of CT Codes Below Comparison Rate	62.5%	97.0%
75 - 100% Below the Comparison Rate	28.1%	15.2%
50 - 74% Below the Comparison Rate	31.3%	45.5%
25 - 49% Below the Comparison Rate	3.1%	36.4%
0 - 24% Below the Comparison Rate	0.0%	0.0%
Percentage of CT Codes Above the Comparison Rate	37.5%	3.0%
1 - 24% Above the Comparison Rate	25.0%	0.0%
25 - 49% Above the Comparison Rate	6.3%	3.0%
50 - 74% Above the Comparison Rate	6.3%	0.0%
75 - 99% Above the Comparison Rate	0.0%	0.0%
100% and Above the Comparison Rate	0.0%	0.0%

Summary of Physical and Occupational Therapy Fee Comparisons		
	CT compared to Five-State Average	**CT compared to Medicare**
Estimated Current Expenditures	$3,764,637	N/A
Amount Excluded (No Match or Outlier)	$120,238	N/A
Estimated Expenditures at Five-State Benchmark	$4,984,980	N/A
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	$1,220,343	N/A
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	32.4%	N/A
Estimated Current Expenditures	N/A	$3,739,538
Amount Excluded (No Match)	N/A	$145,336
Estimated Expenditures at Medicare Rate	N/A	$6,693,124
Difference Between Estimated Current Expenditures and Estimated Expenditures at Medicare Rate	N/A	$2,953,586
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Medicare Rate	N/A	79.0%

Observations

Connecticut Medicaid rates overall compare favorably to the Five-State Average rates, although there is variation in the comparison rate percentages. Connecticut Medicaid rates are generally lower than the Medicare rates. Analysis of paid claims data indicates that there was no utilization for 29 out of the 74 codes on the Independent Physical Therapy and Occupational Therapy fee schedule during CY 2023.

Alternative Analyses

To fulfill the requirements of Public Act 23-186, Myers and Stauffer compared Connecticut's rates to the rates of comparison states and to Medicare using a more limited methodology for certain services as follows:

- *For Chemical Maintenance, an analysis of the service and methodology is provided.*
- *For FQHCs, a limited number of data points to other states' data points are compared only where they were comparable.*
- *For Hospice, CMS defines the minimum rate for each state and, as such, comparisons are not useful. In this section, the CMS defined methodology is provided.*
- *For hospital services, Connecticut base rates (i.e., average cost per discharge) are compared to the base rates of other states and Medicare only where the same software is used to assign discharges to diagnosis related groups.*
- *For ICFs, nursing facilities, and PRTF private facilities, Connecticut base rates are compared to the base rates of other states.*

A Five-State Comparison benchmark rate or a Medicare benchmark for the above services was not created to estimate the impact of changing the Connecticut rates because of the difficulties associated with the comparisons. The analyses are presented below.

Chemical Maintenance Clinics

Myers and Stauffer reviewed 2 codes and rates for Chemical Maintenance Clinic services in the Connecticut Medicaid program. Services include in-person medication administration, take-home medication doses, and in-person clinical services provided at the clinic. Connecticut's current provider-specific reimbursement schedule is based on a legislatively mandated minimum rate, an analysis of provider cost reports, paid claims data, subject matter expert input regarding payment methods, providers' budget forecasts and financial information, and stakeholder input.

This methodology is in contrast to the methodologies used by the comparison states:

- *Maine pays for these services as part of its Opioid Health Homes program and pays a per member per month rate.*
- *Massachusetts and New York pay a weekly bundled rate.*
- *New Jersey and Oregon pay a fee-for-service rate based on service or medication.*

Because of the differences in the approaches used by Connecticut and the comparison states, Myers and Stauffer was not able to calculate benchmarks and conduct a comparison of fees for codes to the benchmarks.

It was also not possible to compare Connecticut rates to those used by Medicare, which covers medication assisted treatment, but through several mechanisms:

- *Medicare Part B: Covers methadone when it is obtained through an Opioid Treatment Program (OTP).*
- *Medicare Part A: Covers methadone when a patient is in an inpatient hospital setting.*
- *Medicare Part D: May cover drugs like methadone, buprenorphine, naloxone, and naltrexone.*

Medicare OTP rates include weekly bundles that vary greatly based on the type of medication and method of administration. Medicare also allows for intensive outpatient treatment and add-ons to the rate for acuity based on the needs of the individual receiving treatment, including take-home supplies of medication. OTP rates vary in Medicare from a low of $259 to more than $5,433 per instance based upon type of medication and administration. Due to the variance in coverage and method of administration, Medicare did not serve as a reasonable comparison point.

Federally Qualified Health Centers (FQHCs)

Requirements for Reimbursement

The federal Benefits Improvement and Protection Act (BIPA), codified at section 1902(bb) of the Social Security Act, requires states to use a Prospective Payment System (PPS) payment methodology for FQHCs.[20] Under this federally required approach, which provides federal requirements that are unique to FQHCs, rates for FQHCs are calculated based on historical cost data from each FQHC and annually adjusted for inflation using the Medicare Economic Index (MEI) for the fiscal year. Federal law also requires states to update each FQHC's PPS encounter rate "to take into account any increase or decrease in the scope of services furnished by the [FQHC] during that fiscal year." As a result, DSS has adjusted the FQHC rates each year. States have the flexibility under federal law to design and implement an Alternative Payment Methodology (APM)if the appropriate statutory requirements are met. Under federal law, an APM for FQHCs must not be less than what each FQHC would have received under its PPS rate, and both the state and the FQHC must agree to the APM.

Medicare uses a different methodology than that used by states. CMS establishes a single national rate, but then makes adjustments based on a Geographic Adjustment Factor. CMS also makes additional adjustments to certain visit types and if the individual is new to that FQHC. Based on these additional adjustments, Medicare does not provide rates that are relevant for comparison to state rates that are based on costs and scope of practice.

Each of the comparison states uses at least one APM approach for FQHC reimbursement. More information about some examples of APMs for FQHC reimbursement used in other states' Medicaid programs is provided in Appendix C.

Development of Methodology for Comparison of Rates

Comparison of FQHC rates across states should consider that FQHC rates are provider-specific and based on individual provider's historical costs as referenced above consistent with federal law. In addition, to the provider-specific base rates, there may be subsequent adjustments to each FQHC's rates based on approved rate increases in response to FQHCs' requests documenting a change in scope. To address these issues, the minimum, maximum, median, and average FQHC rates for Connecticut were determined for comparison to the rates of three comparison states: Maine, New Jersey, and New York. Rates for Oregon and Massachusetts were not publicly available. Myers and Stauffer analyzed each FQHC service category independently to determine the respective minimum, maximum, median, and average rates for FQHCs in each state and made comparisons only if the other states' FQHC rates were for the specific service being analyzed (medical, dental, or behavioral health). In those states that calculated only a single FQHC encounter rate that did not vary according to the category of service (Maine, New Jersey, and New York), Myers and Stauffer compared the Connecticut rate for each service

[20] Encounter- based rates were established using a baseline encounter rate for each FQHC in existence during FY 1999 and 2000. The two-year average encounter rate calculated from these reports is the baseline encounter rate.

to the single rate from the comparison states. In all cases, the comparisons to other states' rates use the BIPA rates, and not APM rates.

There are limitations regarding the analyses of rates and comparisons; these limitations are primarily rooted in the inconsistencies and lack of granularity in data across the comparison states. Some of the comparison states with available data, in contrast to Connecticut, do not have rates for specific service categories (medical, dental, and behavioral health), which creates some distortion in rate comparisons. Therefore, the findings of this analysis should be interpreted with caution.

FQHC Medical Services

FQHCs offer comprehensive medical and primary care services, including preventive care, diagnosis, and treatment of acute and chronic illnesses. The comparison of rates for medical services is shown in *Table* 32 below using percentages that represent the relative difference between minimum, maximum, median, and average encounter rates for these states in each comparison state compared to Connecticut**.**

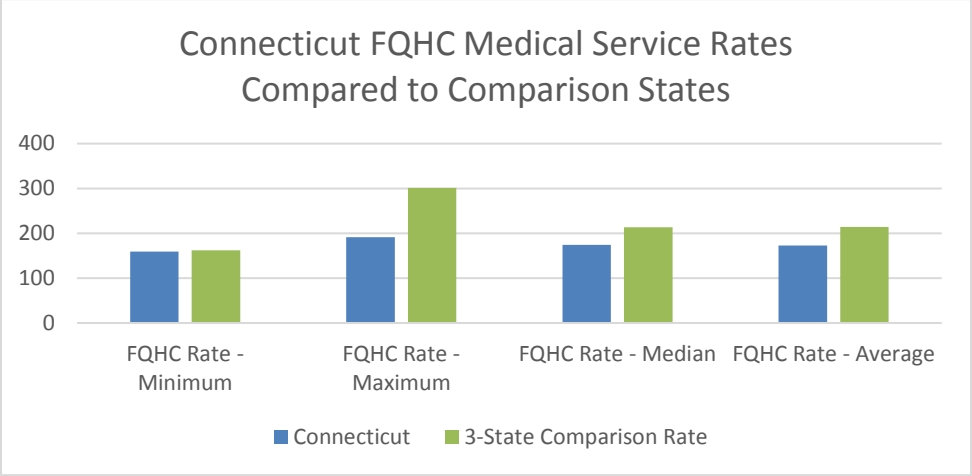
Table 32: Summary of FQHC Medical Services Comparison Results

Comparison of FQHC Medical Encounter Rates: Connecticut vs Selected Comparison States (% Relative to Connecticut)[21, 22]									
	CT[23]	ME[24]		NJ[25]		NY[26]		Average of Comparison States	
Rate Statistic	Rate	Rate	CT rate as a percent of Comparison rate	Rate	CT rate as a percent of Comparison rate	Rate	CT rate as a percent of Comparison rate	Rate	CT rate as a percent of Comparison rate
Minimum	$159.44	$143.61	111.0%	$220.83	72.2%	$121.30	131.4%	$161.91	98.5%
Maximum	$191.04	$276.14	69.2%	$228.86	83.5%	$399.47	47.8%	$301.49	63.4%
Median	$174.16	$181.06	96.2%	$228.86	76.1%	$231.10	75.4%	$213.67	81.5%
Average	$172.62	$193.79	89.1%	$225.18	76.7%	$223.99	77.1%	$214.32	80.5%

Further illustration of the rate comparisons is shown in Figure 3.

[21] State BIPA PPS encounter rates were used exclusively in this analysis; actual payments for some codes for the comparison states could be higher based on APMs.
[22] FQHC-specific PPS rates are not transparent in Massachusetts and Oregon and were excluded from the medical services analysis.
[23] CT.gov. Federally Qualified Health Center (FQHC) Medicaid Reimbursement.
[24] Maine.gov. 2023 FQHC Rates.
[25] https://www.njmmis.com/downloadDocuments/FQHC2024.pdf
[26] New York State Department of Health. FQHC Rates (posted 4/9/2024).

Figure 3: FQHC Medical Service Rate Comparison



FQHC Dental Services

The comparison of rates for dental services is shown in *Table 33* below using percentages that represent the relative difference between minimum, maximum, median, and average encounter rates for these states in each Comparison State compared to Connecticut.

Table 33: Summary of FQHC Dental Services Comparison Results

Comparison of FQHC Dental Encounter Rates: Connecticut vs Selected Comparison States (% Relative to Connecticut)[27, 28]									
	CT[29]	ME[30]		NJ[31]		NY[32]		Average of Comparison States	
Rate Statistic	Rate	Rate	CT rate as a percent of Comparison Rate	Rate	CT rate as a percent of Comparison Rate	Rate	CT rate as a percent of Comparison Rate	Rate	CT rate as a percent of Comparison Rate
Minimum	$145.72	$150.91	96.6%	$220.83	66.0%	$133.05	109.5%	$168.26	86.6%
Maximum	$174.17	$276.14	63.1%	$228.86	76.1%	$399.47	43.6%	$301.49	57.8%
Median	$160.75	$194.41	82.7%	$228.86	70.2%	$239.77	67.0%	$221.01	72.7%
Average	$160.76	$197.50	81.4%	$225.80	71.2%	$233.75	68.8%	$219.02	73.4%

[27] State BIPA PPS encounter rates were used exclusively in this analysis; rates from the comparison states could be higher based on APMs, causing the comparison percentages shown here to be lower.
[28] FQHC-specific PPS rates are not transparent in Massachusetts and Oregon and were excluded from the dental services analysis.
[29] CT.gov. Federally Qualified Health Center (FQHC) Medicaid Reimbursement.
[30] Maine.gov. 2023 FQHC Rates.
[31] https://www.njmmis.com/downloadDocuments/FQHC2024.pdf
[32] New York State Department of Health. FQHC Rates (posted 4/9/2024).

FQHC Behavioral Health Services

FQHCs provide behavioral health services that include mental health counseling, substance use disorder treatment, and psychiatric services. The comparison of rates for behavioral health services is shown in Table 34 below using percentages that represent the relative difference between minimum, maximum, median, and average encounter rates for these states in each Comparison State compared to Connecticut.

Table 34: Summary of FQHC Behavioral Health Services Comparison Results

Comparison of Behavioral Health Encounter Rates: Connecticut vs Selected Comparison States (% Relative to Connecticut)[33]									
Rate Statistic	CT[34]	ME[35]		NJ[36]		NY[37]		Average of Comparison States	
	Rate	Rate	CT rate as a percent of Comparison Rate	Rate	CT rate as a percent of Comparison Rate	Rate	CT rate as a percent of Comparison Rate	Rate	CT rate as a percent of Comparison Rate
Minimum	$175.93	$143.61	122.5%	$220.83	79.7%	$121.30	145.0%	$161.91	108.7%
Maximum	$226.64	$276.14	82.1%	$228.86	99.0%	$399.47	56.8%	$301.49	75.2%
Median	$193.11	$181.06	106.7%	$228.86	84.4%	$234.06	82.5%	$214.66	90.0%
Average	$193.17	$193.79	99.7%	$225.18	85.8%	$225.07	85.8%	$214.68	90.0%

Observations

In general, as shown above and subject to the limitations regarding comparability of Connecticut rates to those of other states where data was available, Connecticut consistently pays less than the comparison states included in the analysis. However, the Connecticut minimum rate for behavioral health services is higher compared to the Three-State Average minimum rate. As referenced above, there are significant limitations in comparisons across states because:

- *Every FQHC's rate in every state was initially set based on cost data unique to each FQHC.*
- *Each FQHC has also been subject to the potential of increases based on a change in scope of services provided that are also inherently specific to each FQHC.*
- *States have different policies related to billing for services that affect comparison results. For example, states differ in whether they allow FQHCs to bill multiple encounters on the same*

[33] State BIPA PPS encounter rates were used exclusively in this analysis; rates from the comparison states could be higher based on APMs, causing the comparison percentages shown here to be lower.
[34] CT.gov. Federally Qualified Health Center (FQHC) Medicaid Reimbursement.
[35] Maine.gov. 2023 FQHC Rates.
[36] https://www.njmmis.com/downloadDocuments/FQHC2024.pdf
[37] New York State Department of Health. FQHC Rates (posted 4/9/2024).

day for the same patient. Additional information about billing policies is provided in Appendix A, "Methodology Comparison."

- *There are challenges in comparing service-specific encounter rates in Connecticut (for medical, behavioral health, and dental) that are inherently not comparable to an overall encounter rate in the comparison states that do not differentiate by the type of service provided.*

Inpatient and Outpatient Hospital Rates

Due to fundamentally different methodologies for reimbursing inpatient hospital and outpatient hospital services, it is difficult to develop a meaningful comparison of reimbursement rates for hospital services across state Medicaid programs and compared to Medicare. For inpatient hospital services, Connecticut uses the Diagnosis Related Groups (DRGs) methodology, which is a patient classification system that provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. Historically, there have been four major versions of the DRG classification system in use: classic Centers for Medicare and Medicaid Services (CMS) DRGs, Medicare Severity DRGs (MS-DRGs), All Patient DRGs (AP-DRGs), and All Patient Refined DRGs (APR-DRGs). The classic CMS DRGs (prior to FY 2008) and MS-DRGs (beginning in FY 2008) are used by Medicare. Connecticut uses the APR-DRGs, which are an expansion of the basic DRGs to be more representative of non-Medicare populations such as pediatric patients. The APR-DRGs incorporate severity of illness subclasses into the AP-DRGs. [38]

Within the inpatient hospital methodology, Connecticut pays for behavioral health, rehabilitation services, and chronic disease hospitals using a per diem approach. Inpatient stays coded to a behavioral health or rehabilitation DRG are paid the hospital's assigned per diem rate rather than the DRG rate. Per diems are also set for child psychiatric hospitals. There is a single per diem rate assigned to rehabilitation hospitals and hospital specific per diem rates are also established for chronic disease hospitals.

For outpatient hospital services, Connecticut, Maine, and Medicare use the Ambulatory Payment Classifications (APCs) approach. The APC methodology groups items and services that are similar clinically and in terms of resource use. The APCs are designed and implemented for the specific needs of the Medicare population and are designed to categorize only some of the services provided in an ambulatory care setting. Many other ambulatory care services in Connecticut Medicaid are paid using fee schedules in an APC-based outpatient prospective payment system. Services that are paid via a fee schedule include laboratory, pathology, physical therapy, mammography, non-implantable prosthetics, and DME.

[38] https://3mhis-customersupport.s3.amazonaws.com/aws/docs/Groupers/All_Patient_Refined_DRG/Methodology_overview_GRP041/grp041_aprdrg_methodology_overview.pdf?AWSAccessKeyId=AKIAQW57BTWS32KLYSMB&Expires=1719856894&Signature=C%2BezwQ1ei6HlJ%2BsDAEJOnPkpRI4%3D

As broader context for hospital reimbursement in Connecticut, there is a formal legal settlement agreement effective from state fiscal year (SFY) 2020 through SFY 2026 (expiring June 30, 2026), between the state and the in-state privately operated acute care general hospitals. The terms of this agreement provide for increases in overall payments to hospitals without using a standardized methodology more commonly in place in comparison states or used by Medicare.

Connecticut Rate Methodology for Inpatient Services as Compared to Comparison States

For comparison of inpatient hospital services, only the rates for Massachusetts, New Jersey and New York, which also use APR-DRGs, were used because states with other methodologies are not comparable. The approaches that are used by these states are summarized in Table 35.

Table 35: Characteristics of DRG Methodologies in Comparison States

Characteristics of DRG Methodologies in Comparison States			
State	**Base Rates**	**APR-DRG Weights**	**Payment Components (Excluded from Analyses)**
Connecticut	• Peer group base rates • Annual updates for wage index and indirect medical education (IME)	• National weights • Annual updates	• Capital add-on per claim • Cost outliers
Massachusetts	• Hospital-specific base rates • Annual updates	• State-specific weights • Annual updates	• Pediatric base rate add-ons vary at 6%, 25%, or 67% • Cost outliers
New Jersey	• Statewide base rate (with 3 potential add-ons) • Annual updates	• State-specific weights • Annual updates	• Add-on rates of 10 or 15% for high volume hospitals (critical access, critical service, and pediatric service) • Cost outliers
New York	• Hospital-specific base rates • Annual updates	• State-specific weights • Evaluated every 4 years, but unchanged since 2018	• Capital add-on per claim • Direct and indirect graduate medical education add-on • Inpatient ambulance add-on • Inpatient nursing school costs add-on • Physician teaching election amendment add-on • Cost outliers

Table 36 provides additional information about services that are excluded from the DRG methodology by Connecticut Medicaid and comparison states.

Table 36: DRG Exclusions

DRG Exclusions				
Exclusion	**Connecticut**	**Massachusetts**	**New Jersey**	**New York**
Inpatient Psychiatric	X	X	X	X
Cancer Hospitals				X
Chemical Dependency Hospitals				X
Children's Hospitals				X
Critical Access Hospitals				X
Chronic Disease Hospitals	X	X	X[39]	X[40]
Rehabilitation Hospitals	X	X	X	X
Rehabilitation Stays				
Substance Abuse Detox Hospitals				X

Connecticut Medicaid inpatient rates could not be compared to Medicare rates because of the different methodologies that each program uses. For the state comparisons, Connecticut Medicaid claims for 2023 were assigned to more than 1,300 APR-DRG classifications. The Connecticut base DRG rate was compared with the median base rates of the three comparison states to take into consideration the different base rates in the comparison states, i.e., where there were hospital-specific or peer group rates in place. Payment amounts, i.e., base rates multiplied by the relative weights for each DRG were also compared. Supplemental payments and outlier payments and other add-ons, e.g., graduate medical education and indirect medical education, were further excluded due to wide variation in amounts and methodologies between states and dependency on specific claim or hospital criteria, such as age of the patient or cost of the stay. A summary of the results of these analyses is presented in *Table 37*.

Table 37: Inpatient Hospital Summary of Results

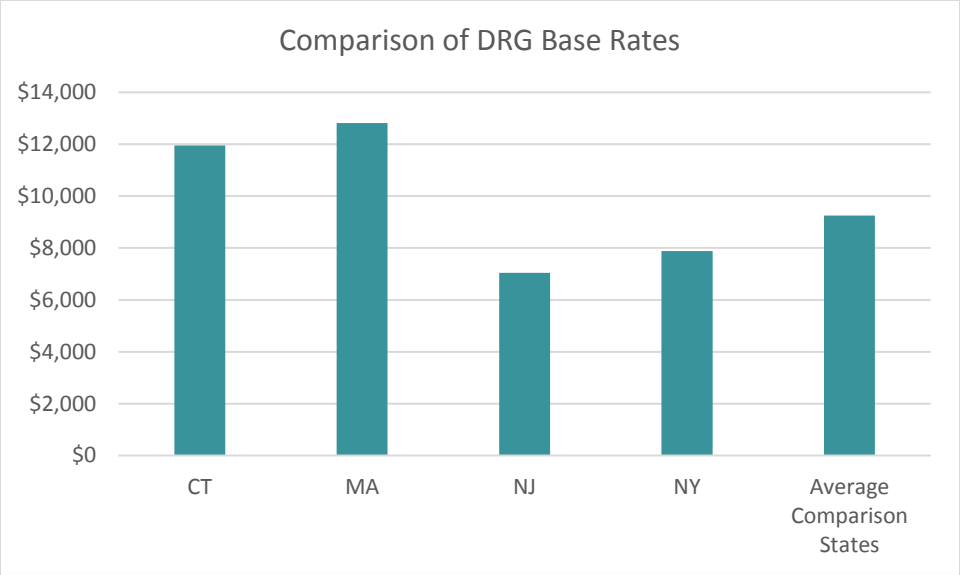
Inpatient Hospital Summary of Results					
	Connecticut	**Massachusetts**	**New Jersey**	**New York**	**Average of Comparison States**
Median	$11,954.50	$12,810.86	$7,046.96	$7,881.86	$9,246.54

[39] Referred to as a Specialty Hospital in New Jersey.
[40] Referred to as a Long Term Acute Care Hospital in New York.

Inpatient Hospital Summary of Results					
	Connecticut	**Massachusetts**	**New Jersey**	**New York**	**Average of Comparison States**
CT as a % of Comparison Rate[41]		93.3%	169.6%	151.7%	129.3%
Estimated Total Expenditures	$928,545,868	$1,034,769,919	$901,739,022	$737,319,530	$944,620,767
CT as a % of Other States		89.7%	103.0%	125.9%	98.3%
Expenditure per Claim	$11,110.20	$12,381.19	$10,789.45	$8,822.14	$11,302.54

Figure 4 provides a graphical comparison of DRG base rates by comparison state along with the average of all comparison states.

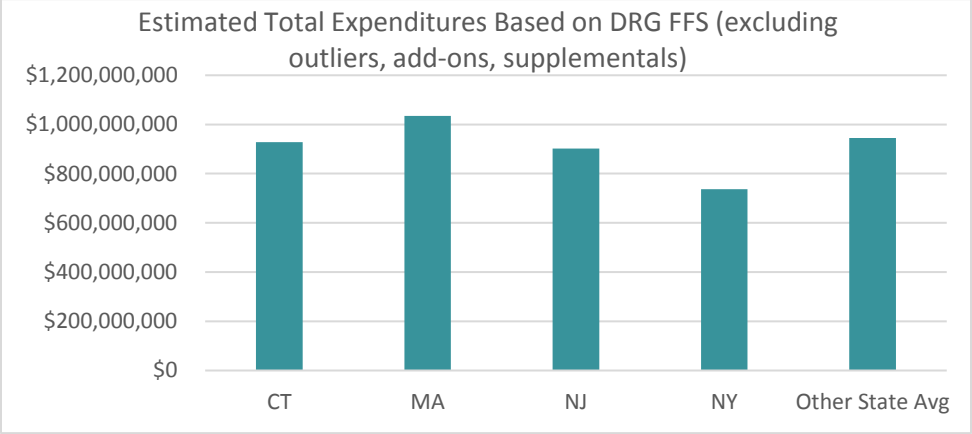
Figure 4: Comparison of DRG Base Rates



Inpatient hospital total expenditures by state are illustrated in *Figure 5.*

[41] Comparison of Hospital Inpatient DRG Base Rates: Connecticut vs Selected Comparison States (% Relative to Comparison States)

Figure 5: Inpatient Hospital Estimated Total Expenditures



The methodology used to pay for inpatient pediatric stays/children's hospitals used by Connecticut Medicaid and the comparison states were also compared, as applicable. *Table 38* provides a summary of the different methodologies by state.

Table 38: Children's Hospitals and Pediatric Stays

Children's Hospitals and Pediatric Stays	
State	**Methodology**
Connecticut	• Children's hospital-specific APR-DRG base rate • 10-30% increase when accounting for wage index and IME • Separate disproportionate share hospital (DSH) payment pool, children's hospital practitioner supplemental payment, and exemption from the state's hospital user fee (which is a healthcare-related tax for purposes of federal Medicaid law).
Massachusetts	• Freestanding Pediatric Acute Hospital (FPAH) discharges with a DRG weight >= 3.0 receive a 67% increase to the base rate • Acute, non-FPAH pediatric discharges receive a 25% increase to the base rate • Acute pediatric, non-FPAH, non-pediatric discharges receive a 6% increase to the base rate • Annual infant outlier payments total $50,000, split between eligible hospitals; annual pediatric outlier payments of $1,000 each are issued • A diem rate of $954.59 is assigned for all behavioral health stays, plus an amount ranging from $350 to $3,635 per admission based on admission criteria (age, diagnosis, admission day of week)
New Jersey	• Hospitals providing pediatric critical services are paid APR-DRG base rate add-on of either 10% or 15% • Children's hospital per diem is cost-based ($3,400)
New York	• Children's hospitals are exempt from APR-DRG • A daily rate of $2,188.13 is assigned

Table 39 provides the results of an analysis comparing the Connecticut Medicaid children's hospital rates to those of three comparison states.

Table 39: Children's Hospitals and Pediatric Stays

Inpatient Hospital Median Per Diem Service Rates[42]									
Service	CT	MA		NJ		NY		Average of Comparison States	
	Per Diem Rate	Per Diem Rate	CT Rate as a Percent of Comparison Rate	Per Diem Rate	CT Rate as a Percent of Comparison Rate	Per Diem Rate	CT Rate as a Percent of Comparison Rate	Per Diem Rate	CT Rate as a Percent of Comparison Rate
Behavioral Health Hospital	$1,076.48	$3,129.59	34.40%	$1,256.00	85.71%	$1,219.15	88.30%	$1,868.25	57.62%
Rehabilitation Hospital	$1,512.59	$1,382.58	109.40%	$1,407.50	107.47%	$1,232.54	122.72%	$1,340.87	112.81%
Chronic Disease Hospital	$950.89	N/A	N/A	N/A	N/A	$1,105.23	86.04%	$1,105.23	86.04%
Children's Hospital	N/A	N/A	N/A	$3,400.00	N/A	$2,188.13	N/A	$2,794.07	N/A

Observations

The comparison of hospital expenditures that relies on the calculation derived from multiplying the base rate by the relative weight of the DRG assigned to a claim suggests that Connecticut compares favorably to the comparison states, i.e., Connecticut expenditures are 98% of comparison states' expenditures for services that are paid based on DRGs. A cautionary note, however, is that this comparison does not represent total hospital payments. The comparison of estimated expenditures takes into consideration both the base rates and relative weights used for payment calculations across states, but still excludes outliers, add-on payments, and any supplemental payments.

For services paid using per diem rates, the Connecticut Medicaid rates are generally higher for rehabilitation hospitals, but lower for behavioral health than the comparison states.

Outpatient Hospital Services

Connecticut uses the same methodology for outpatient hospital reimbursement as Medicare, and payment for most procedures is calculated through a conversion factor multiplied by the relative weight of the procedure.[43] Connecticut updates the procedure code relative weights annually to align with Medicare. Conversion factors are specified in the Medicaid state plan. Wage index adjustments to conversion factors are based on the original Medicare assignment. Connecticut Medicaid conversion

[42] The rates in the table are based on a median of the state-specific rate for the type of hospital stay.

[43] The relative weight for a service is based on the geometric mean cost of services in their Ambulatory Payment Classification (APC) group, and measures the resources needed to provide the service. The conversion factor is a dollar amount that translates relative weights into payment amounts. It is intended to represent the average cost of a Medicare case.

factors are approximately 93% of Medicare. As a result, Medicaid reimbursement is approximately 93% of Medicare reimbursement.

For the comparison of outpatient hospital services, Myers and Stauffer compared the Connecticut fee schedule and conversion factors to Medicare's fee schedule and conversion factors. Because of the similarities between the Connecticut and Medicare APC methodologies, this was determined to be the most accurate comparison.
Table 40 provides a summary of the comparison of Connecticut rates to the Medicare rates. Maine is the only comparison state that also uses the Medicare methodology, and payments are based on 100% of the Medicare rates (so the results of the comparison to Medicare are the same as the comparison to Maine Medicaid). The other comparison states – Massachusetts, New Jersey, and New York – use the Enhanced Ambulatory Patient Grouping System (EAPG), which is designed for an all-patient population, to explain the amount and type of resources used in an ambulatory visit or define the product of ambulatory care. [44].

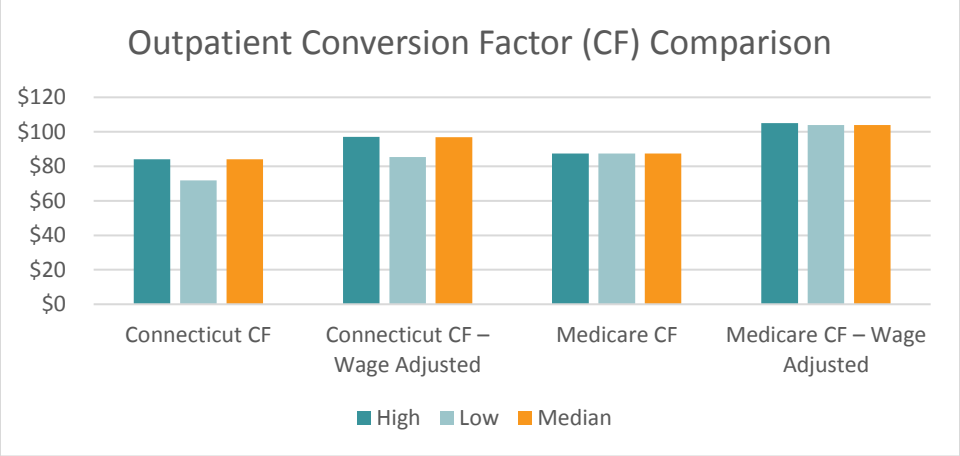
Table 40: Outpatient Hospital Comparison

Outpatient Hospital Comparison				
	Connecticut Conversion Factor	**CT Conversion Factor Wage Adjusted**	**Medicare Conversion Factor**	**Medicare Conversion Factor Wage Adjusted**
High	$84.13	$97.07	$87.38	$104.98
Low	$71.76	$85.38	$87.38	$103.97
Median	$84.13	$96.94	$87.38	$103.97
Medicaid Percentage of Medicare (Median Values) = 93%				

This data is further illustrated in Figure 6.

[44] https://www.3m.com/3M/en_US/health-information-systems-us/drive-value-based-care/patient-classification-methodologies/enhanced-apgs/#:~:text=Medicare%20Ambulatory%20

Figure 6: Outpatient Conversion Factor Comparison



Observations

Comparisons are made of base payments only. The comparisons do not take into account payment for outlier cases or payments for medical education, which will affect the actual comparison metrics. These additional payments may be based on patient-specific information, which was not available for the Myers and Stauffer analysis. In addition, as in Connecticut, the comparison states use various types of healthcare-related tax funding structures and supplemental payment methodologies unique to each state that result in additional payments that would also change the metrics—and which are so unique to each state that it is not possible to compare across states. In addition, not all of this data is publicly available for comparison purposes.

Hospice

Federal statute at 42 USC § 1396a(a)(13)(B) requires that each state's Medicaid hospice rates be no lower than, and be generated using the same methodology as, Medicare's hospice rates. Additional information about the hospice rates may be found in Appendix A. Each of the comparison states follow this methodology, with the exception of Maine, which pays 123% of the CMS published rates for routine home care (for both days 1-60 and more than 60 days).[45]

Intermediate Care Facilities (ICFs) (Private)

Because Connecticut Medicaid rates for private ICFs are location specific, an alternate methodology for the rate comparisons was used for these services, as shown in *Table 41*. Connecticut Medicaid rates were compared to rates in the states of Maine and New York. Rates for ICF services in Massachusetts,

[45] https://www.medicaid.gov/medicaid/benefits/hospice-benefits/hospice-payments/index.html#:~:text=Outside%20of%20the%20payments%20made,last%20seven%20days%20of%20life

New Jersey, and Oregon were not available and were excluded from analysis. Similar to other services with cost-based provider-specific rates, a comparison based on the minimum, median, maximum, and average rate in the comparison states is provided. Medicare does not cover ICF services, so it is not possible to compare Connecticut Medicaid to Medicare.

Table 41: ICF (Private) Fee Comparisons

Comparison of ICF (Private) Rates (% Relative to Connecticut)[46]							
	Connecticut	Maine		New York		Average of Comparison States	
Rate Statistic	Rate	Rate	CT rate as a percent of Comparison rate	Rate	CT as a percent of Comparison Rate	Rate	CT as a percent of Comparison Rate
Minimum	$501.00	$455.51	110.0%	$378.25	132.5%	$416.88	120.2%
Maximum	$876.81	$1,339.80	65.4%	$1,102.69	79.5%	$1,221.25	71.8%
Median	$598.22	$778.61	76.8%	$545.96	109.6%	$662.28	90.3%
Average	$605.06	$794.81	76.1%	$575.28	105.2%	$685.04	88.3%

Observations

Connecticut rates for ICF services are generally slightly above the comparison states' minimum rate, and below the maximum, median, and average rates. Connecticut Medicaid rates were rebased for SFY 2024, using more recent cost report submissions and a 2% adjustment factor.

Nursing Facilities

Connecticut Medicaid nursing facility rates are per diem rates based on actual costs up to a predetermined ceiling. The cost-based rates are provider-specific and adjusted to account for the acuity of residents in each facility.[47] Like Connecticut, four of the five comparison states use a case mix reimbursement system. Case mix reimbursement systems are either based on Resource Utilization Groups (RUGs) or the Patient Driven Payment Model (PDPM). Both RUGS and PDPM are methods for classifying residents into groups based on their condition and the care they receive.

States apply other adjustments, such as for high-need residents; for ventilator services; for treating residents with certain mental health or other cognitive impairments; and for serving patients with AIDS, multiple sclerosis, or other extreme care needs. States may also make supplemental or incentive payments to nursing facilities. Supplemental payments are typically lump-sum payments targeted to a

[46] ICF rates in Massachusetts, New Jersey and Oregon were not available and were excluded from the ICF analysis.
[47] Nursing facility "case mix" determines the overall differences within a group of residents and compares individual cases relative to one another within the mix. It is a means to identify acuity differences among residents within a population.

group of facilities to encourage providers to implement certain quality initiatives, support a particular policy goal, or meet specific predetermined metrics.[48]

While the Connecticut Medicaid acuity adjusted rate methodology is comparable to the methodologies used by the comparison states (with the exception of Oregon), a comparison of per diem rates would be based, in part, on costs specific to each facility and the acuity of the residents in each facility at a given point in time across each of the states. Myers and Stauffer instead compared the Connecticut rates to the ranges of rates in the other states, with the comparison points being the lowest rate in each comparison state, the median rate, and the maximum rate. A Five-State Average rate for the comparison states was compared to the average Connecticut rate.

Myers and Stauffer did not include a comparison to Medicare rates for nursing facilities, as Medicare rates are developed for short-stay acute residents only; the services provided to these residents are not comparable to the services that are provided to long-stay Medicaid residents. This difference also highlights a fundamental difference between Medicaid, which includes both health and long-term care coverage, compared to Medicare, which does not provide long-term care.

Myers and Stauffer compared Connecticut's lowest rate, the median rate, the maximum rate, and the average rate for all nursing facilities as summarized in Table 42. Connecticut rates range from about 88% to 92% of the comparison states' rates, using each of the comparison points considered for this analysis. *Table 42* also provides the number of providers in each state and identifies the comparison states that use acuity systems for additional context.

[48] Medicaid and CHIP Payment and Access Commission. Nursing Facility Fee-for-Service Payment Policy. December 2019.

Table 42: Comparison of Connecticut NF Per Diem Rates to Rates of Comparison States[49]

Comparison of Connecticut NF Per Diem Rates to Rates of Comparison States								
	CT[50]	MA[51]	ME	NJ	NY	OR[52]	CT as % of Five-State Comparison	Five-State Comparison [53]
Number of Providers	185	344	90	319	594	130		
Low Per Diem	$230.57		$166.21	$232.97	$161.58	$478.15	88.8%	$259.73
High Per Diem	$454.15		$468.03	$358.30	$658.48	$478.15	92.5%	$490.74
Median Per Diem	$298.13		$302.51	$270.68	$271.38	$478.15	90.2%	$330.68
Average Per Diem	$297.42	$326.00	$305.11	$271.77	$279.35	$478.15	87.8%	$338.82
Acuity Index	Yes	Yes	Yes	Yes	Yes	No		

[49] Connecticut rates are based on final rates inclusive of add-ons for various wage and benefit programs. It appears that nursing facility rates published by the comparison states are also inclusive of various add-ons, but it is not possible to determine base rates for any of these states based on publicly available data.

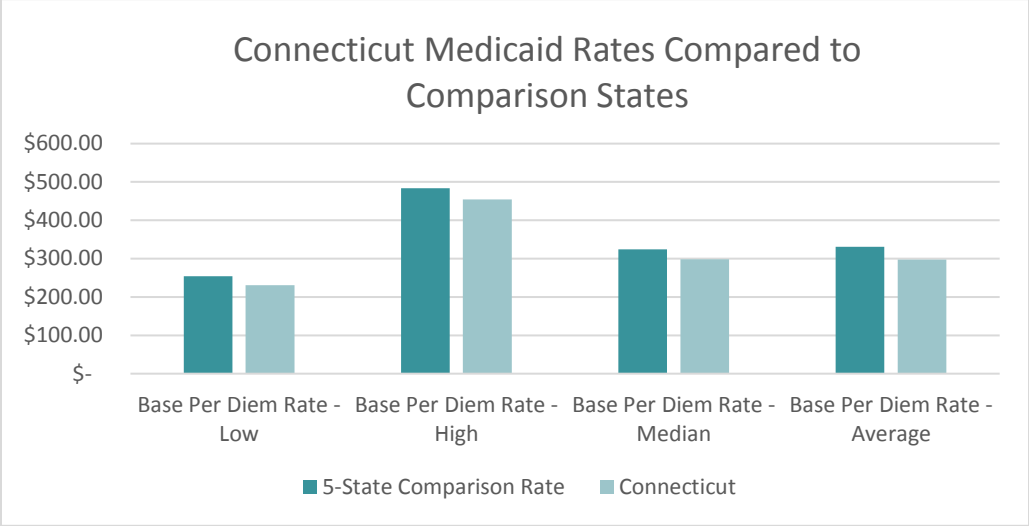
[50] The acuity-based reimbursement system was implemented on July 1, 2022, and phased-in over three-years from July 1, 2022 to July 1, 2024. Phase in parameters also included a stop gain and stop loss limit to the Medicaid rate during each year of the phase-in to provide rate predictability for providers during the phase-in period. The analysis and comparison of Connecticut rates was completed prior to July 1, 2024, when the stop-loss/stop-gain provisions of the nursing facility rate methodology terminated. Connecticut rates will continue to change quarterly.

[51] Massachusetts rates are resident-specific; and Myers and Stauffer was unable to obtain all rates for comparison. MassHealth provided the average rate.

[52] Oregon has a statewide nursing facility rate.

[53] Average of rates in comparison states.

Figure 7: Medicaid Rate State Comparison



Observations

In interpreting the results of the comparison, it should be noted that while all comparison states included in this study use a cost-based reimbursement system to set nursing facility rates, each system is unique in the cost centers established, the specific costs allowed in each cost center, and ceilings calculated for each cost center. In addition, each of the states reviewed has a different proportion of the Medicaid population that are using nursing facilities vs. other long-term services and supports. In Oregon, for example, 92% of the individuals accessing long-term care obtain those services in the home and community setting, while only 4% access care in nursing facilities. In contrast, in Connecticut, 70% of individuals accessing long-term care obtain those services in nursing facilities and 30% obtain care in the home and community setting. Research indicates that often states have higher acuity residents in nursing facilities when they use HCBS extensively.[54] This higher acuity could account in part for relatively higher nursing facility costs and rates in one state compared to another and should be considered in the rate comparisons.

Psychiatric Residential Treatment Facilities (PRTFs) (Private)

For private PRTF services, Connecticut Medicaid, as well as most of the comparison states, develops payment rates based on individual provider's costs. Connecticut and Maine both use one statewide rate (Massachusetts' PRTFs are identified as Intensive Residential Treatment Programs). New York has facility-specific rates. New Jersey and Oregon rates are not available and Medicare does not provide coverage for PRTF services. Myers and Stauffer compared the rates using the minimum, maximum,

[54] KFF. How Many People Use Medicaid Long-Term Services and Supports and How Much Does Medicaid Spend on Those People?. Chidambaram, Priya; Burns, Alice. August 14, 2023.

median, and average rates for the comparison states that had comparable rates publicly available, as shown in *Table 43*.

Table 43: Summary of Private PRTF Fee Comparisons

Comparison of Private PRTF Rates: Connecticut vs Selected Comparison States (% Relative to Connecticut)[55]									
	Connecticut	Maine		Massachusetts		New York		Average of Comparison States	
Rate Statistic	Fee Schedule Rate	Fee Schedule Rate	CT as a percent of comparison rate	Fee Schedule Rate	CT as a percent of comparison rate	Fee Schedule Rate	CT as a percent of comparison rate	Fee Schedule Rate	CT as a percent of comparison rate
Minimum	$792.46	$485.72	163.2%	$777.62	102.0%	$906.02	87.5%	$723.12	109.6%
Maximum	$792.46	$485.72	163.2%	$794.19	100.0%	$1,468.81	54.0%	$916.24	86.5%
Median	$792.46	$485.72	163.2%	$785.91	101.0%	$1,136.71	70.0%	$802.78	98.7%
Average	$792.46	$485.72	163.2%	$785.91	101.0%	$1,160.43	68.3%	$810.68	97.8%

Observations

The Connecticut rate is generally in line with the minimum rate of comparison states, but slightly lower than the maximum, median, and average rates. While PRTFs in general provide psychiatric care to children, states' programs can be different based on the ages of the children they serve, and their diagnoses. The PRTF census, and therefore per diem rates based on costs, are greatly affected by the number of children in the custody of child and family services agencies, the transfer of children to out-of-state providers, and the overall availability of beds per capita. All of these factors can contribute to differences in site-specific rates. Like other cost-based programs, internal analysis of the sufficiency of the rate to support the capacity needed within a state may provide a more meaningful analysis than comparisons to other states.

[55] PRTF rates are not publicly available for New Jersey and Oregon and were excluded from the PRTF analysis.

Findings from the Rate Reviews and Comparisons

Selection of Benchmarks and Results of Benchmarking

The benchmarks in this report serve as comparison points, and not recommended reimbursement rates. Ultimately, decisions on investments should be based on access needs and performance outcomes. To apply these comparisons for rebasing rates, DSS should select which benchmarks to use and how they should be applied based on available access data available. Myers and Stauffer developed one approach that relies on using the Medicare fee schedule where code comparisons are possible and, where those comparisons are not possible, using the Five-State Average rate.

This report uses 80% of the Medicare rate as a benchmark for illustrative purposes only. It is not meant to be a recommendation but rather a basis for comparison. DSS should determine the appropriate benchmarks to use for further analyses.

Table 44 illustrates that using 80% of the Medicare and the Five-State Average benchmarks, codes with payments totaling $1.3 billion were benchmarked and broken out as follows: $819.5 million using the Medicare benchmark and $478.3 million using the Five-State Average benchmark. A total of $299.3 million were attributed to non-matched codes, and $4.2 billion were analyzed for the report but not factored into the benchmark. With an annual budget of approximately $10 billion, the remaining $4.5 billion not included in the study includes pharmacy services, reimbursement for which is determined by a complex set of policies at both the federal and state levels that make comparisons difficult; and services that are funded through Certified Public Expenditures, which are funds spent on Medicaid-eligible services and items and then certified by the state. Myers and Stauffer further determined that an estimated additional amount of $300.5 million ($150.3 million state share) would be needed to if DSS applied those benchmarks.[56]

In Table 44, yellow identifies those services that were included in the Phase 1 report, green denotes Phase 2 services, and blue identifies services which were analyzed in Phase 2, but for which a benchmark was not determined.

[56] Calculated at 50% to account for the FMAP as a conservative estimate of the state share necessary. Although 50% FMAP is the default FMAP for Connecticut's Medicaid program, certain populations and service categories have a higher FMAP; the most significant source of higher FMAP is that HUSKY D, which is the Medicaid expansion population established by the federal Affordable Care Act for low-income adults (i.e., other than adults qualifying on the basis of being parent/caretaker, pregnant, and/or disability, etc.).

Table 44: Benchmark Summary Analysis

Benchmark Summary Analysis $ in Millions							
Fee Schedule	**Current Expenditures**	**Expenditures at 80% of Medicare**	**Expenditures at 100% Five- State Comparison**	**Expenditures Associated with Non-Matched Codes**	**Total Expenditures at Benchmark[57]**	**Amount Expenditures would Increase**	**Percent Increase over Current Expenditures**
Physician Outpatient Non Facility[58]	$312.0	$373.2		$51.0	$424.2	$112.2	36.0%
Physician Outpatient Facility	$22.7	$30.4		$0.0	$30.4	$7.7	33.9%
Physician - Anesthesia	$16.8	$21.1		$0.0	$21.1	4.3	25.6%
Physician - Radiology	$45.6	$45.7		$0.9	$46.6	1.0	2.2%
Physician Surgery Non-facility	$77.8	$102.7		$3.2	$105.9	$28.1	36.1%
Physician Surgery Facility	$16.2	$21.3		$0.0	$21.3	$5.1	31.5%
Autism Services	$50.9		$65.0	$0.3	$65.0	$14.1	27.8%
Behavioral Health Clinic	$39.1		$81.4	$3.4	$84.8	$45.7	116.9%
Dental[59]	$179.3		$177.4	$0.9	$178.3	$0.0	0.0%
Acupuncture	$1.9	$2.8		$0.0	$2.8	$0.8	43.6%
ASC	$9.8	$12.8		$0.2	$12.9	$3.2	32.3%
Audiology & Speech Pathology	$2.0	$3.2		$0.1	$3.3	$1.3	64.1%
Chiropractor	$0.5	$0.7		$0.0	$0.7	$0.3	50.9%
Clinic- Outpatient Hospital Behavioral Health	$98.3		$90.9	$22.6	$113.5	$15.2	15.4%
Clinic- Medical	$1.4	$1.7		$0.2	$1.9	$0.5	33.1%
Clinic-Rehab	$14.8	$14.3		$0.6	$15.0	$0.2	1.5%
Dialysis	$10.8	$0.2		$10.5	$10.8	$0.0	0.0%
DME (Cures Act)	$26.2	$11.3		$16.9	$28.2	$2.0	7.6%

[57] Includes increases for only those codes with expenditures that would be below 80%. There is no estimated increase for those codes already above the benchmark. Codes not matched to a benchmark are represented at their current expenditure level.
[58] CMS makes the non-facility and facility designations and sets the Medicare fee higher for some codes because the practitioner is paying for overhead and equipment costs.
[59] Connecticut rates are greater than the Five-State Average rate when both adult and pediatric fee schedules were combined, resulting in no net increase.

Benchmark Summary Analysis $ in Millions							
Fee Schedule	**Current Expenditures**	**Expenditures at 80% of Medicare**	**Expenditures at 100% Five- State Comparison**	**Expenditures Associated with Non-Matched Codes**	**Total Expenditures at Benchmark[57]**	**Amount Expenditures would Increase**	**Percent Increase over Current Expenditures**
DME (Non-Cures Act)[60]	$2.1	$0.0		$2.1	$2.1	$0.0	0.2%
Family Planning Clinic	$8.0		$9.2	$0.8	$10.1	$2.1	25.8%
Hearing Aid and Prosthetic Eye (Cures Act)	$2.5		$3.1	$0.9	$4.1	$1.6	65.8%
Home Health (Procedure Codes)	$187.5		$50.1	$155.4	$205.5	$18.0	9.6%
Independent Radiology	$1.7	$1.1		$0.7	$1.8	$0.1	6.7%
Laboratory	$55.3	$66.1		$0.7	$66.8	$11.4	20.7%
Medical Surgical Supplies (Cures Act)	$15.6	$14.2		$1.4	$15.6	$0.0	0.0%
Medical Surgical Supplies (Non-Cures Act)	$24.1	$0.0		$24.1	$24.1	$0.0	0.0%
Enteral and Parenteral (Cures Act)	$2.8	$2.9		$0.1	$2.9	$0.1	3.8%
Naturopath	$0.7		$1.2	$0.0	$1.2	$0.4	54.1%
Optician/Eyeglasses	$3.7	$4.8		$1.4	$6.2	$2.5	66.1%
Physical and Occupational Therapy	$3.9	$6.7		$0.1	$6.8	$3.0	76.0%
Prosthetic and Orthotic	$12.1	$15.2		$0.7	$15.9	$3.8	31.9%
Transportation	$51.3	$67.0		$0.1	$67.1	$15.9	31.0%
Chemical Maintenance	$52.1				$52.1		
Federally Qualified Health Centers	$280.6				$280.6		
Home Health (Revenue Codes)[61]	$4.7				$4.7		
Hospice	$6.5				$6.5		
ICF	$74.0				$74.0		

[60] The utilization for the procedure codes listed on the CT MEDS-MISC Fee Schedule was combined with the DME (non-Cures Act) amounts.

[61] Home Health procedure codes were compared and benchmarked, home health services that are reported with revenue codes are not comparable across states and were not comparable to other states and were not benchmarked.

Benchmark Summary Analysis $ in Millions							
Fee Schedule	**Current Expenditures**	**Expenditures at 80% of Medicare**	**Expenditures at 100% Five- State Comparison**	**Expenditures Associated with Non-Matched Codes**	**Total Expenditures at Benchmark[57]**	**Amount Expenditures would Increase**	**Percent Increase over Current Expenditures**
Inpatient Hospital (DRG)[62]	$928.5				$928.5		
Inpatient Hospital (Per Diem)	$140.1				$140.1		
Nursing Facilities	$1,622.9				$1,622.9		
Outpatient Hospital	$1,052.4				$1,052.4		
PRTF	$11.9				$11.9		
Total	**$5,471.1**	**$819.5**	**$478.3**	**$299.3**	**$5,770.7**	**$300.5**	**5.5%**
State Share[63]	**$2,735.6**	**$409.7**	**$239.2**	**$149.7**	**$2,885.3**	**$150.3**	

In a separate rate study effort conducted to examine the HCBS waiver rates, rates were modeled to determine the fiscal impact by service type of implementing rate methodology updates using current data. This rate study was also completed in two phases. The first phase studied the HCBS waivers operated by DSS, and the second phase examined the waivers operated by DDS. *Table 45* provides for a breakdown of the modeled payments for DSS waivers by service type.

Table 45: HCBS Rate Study Phase 1 Fiscal Impact by Service Type

HCBS Rate Study Phase 1 DSS Fiscal Impact by Service Type				
	Baseline Model	**Modeled Payments**	**Difference**	**% of Fiscal Impact**
Total Modeled Payments	$706,840,992	$925,250,568	$218,409,576	
Categories expanded below:	**$663,980,160**	**$866,508,964**	**$202,528,804**	**93%**
Personal Care	396,025,280	517,400,275	121,374,995	56%
Tiered Case Management	31,489,039	57,616,440	26,127,401	12%
Companion Services	44,812,419	61,067,904	16,255,485	7%
Adult Family Living	125,969,407	138,828,601	13,132,194	6%
Independent Living Skills Training	36,764,180	47,079,310	10,315,130	5%
Adult Day Health	12,577,169	20,873,300	8,296,132	4%

[62] Estimated expenditures based on DRG claim counts, 2024 DRG weights, and average 2024 DRG payment rates, without outlier payments.
[63] Calculated as 50 percent to account for the FMAP.

HCBS Rate Study Phase 1 DSS Fiscal Impact by Service Type				
	Baseline Model	Modeled Payments	Difference	% of Fiscal Impact
Recovery Assistant	16,615,666	23,643,133	7,027,467	3%
Other Categories	42,860,833	58,741,604	15,880,771	7%
Total	**$706,840,992**	**$925,250,568**	**$218,409,576**	**100%**

Table 46 provides for a breakdown of the modeled payments for DDS waivers by service type.

Table 46: HCBS Rate Study Phase 2 DDS Fiscal Impact by Service Type

HCBS Rate Study Phase 2 DDS Fiscal Impact by Service Type				
	Baseline Model	Modeled Payments	Difference	% of Fiscal Impact
Total Modeled Payments	$842,314,887	$1,023,364,133	$181,049,246	
Categories expanded below:	**$835,674,264**	**$1,014,160,549**	**$178,486,285**	**96%**
Community Living Arrangement	425,016,956	520,776,149	95,759,193	53%
Individualized Home Supports	43,216,742	70,139,979	26,923,237	15%
Continuous Residential Supports	119,281,896	141,764,110	22,482,215	12%
Day Support Options	180,537,218	201,678,766	21,141,548	12%
Supported Employment	52,357,042	59,887,054	7,530,012	4%
Other Categories	6,640,623	9,203,584	2,562,961	4%
Total	**$842,314,887**	**$1,023,364,133**	**$181,049,246**	**100%**

Findings from Review of Current Methodologies and Fee Schedules, Research, and Interviews with DSS Staff

The findings from the rate study focus on Phase 2 services, and also include the results from the Phase 1 study, as relevant, to allow for the development of recommendations that include reimbursement methodologies and rates across all services.

Finding 1: Documentation of Connecticut Medicaid methodologies and fee schedule approaches is inconsistent.

Fee schedule methodologies for some services, for example, the cost-based fee schedules for nursing facilities, ICFs, and FQHCs, are well-documented. For others, such as for some of the Emergency Transportation services, Home Health, and Independent Audiology and Speech and Language Pathology,

there is no documentation. Fee schedule methodologies should be documented and retrievable to support future updates and policy changes.

Finding 2: Connecticut Medicaid is inconsistent in the frequency of, basis and rationale for, and implementation of updates across fee schedules.

The inconsistency in frequency of updates, basis and rationale for, and implementation of updates across fee schedules leads to potential provider equity issues. For example:

- *For a number of fee schedules, Connecticut rates are based on the Medicare Physician Office and Outpatient fee schedule, but the date of the Medicare fee schedule applied varies. Some of the fees for physician services are based on 57.5% of 2007 Medicare; laboratory services fees are based on 70% of 2015 Medicare, and DME fees are based on 85% of 2007 Medicare.*
- *CMS conducts routine maintenance of fee schedules to add new codes, delete old codes, etc., to remain compliant with HIPAA regulations, but does not routinely adjust fees.[64] Fee schedules that were originally developed based on a percent of Medicare have not been updated, so individual comparison rate percentages are inconsistent in comparison to Medicare rates. New codes and rates that are added in subsequent years are set based on more recent Medicare data, creating inequities across providers, and potential financial incentives for the delivery of some services in favor of others because of the payment rates. These inconsistences can be seen in the comparison of Connecticut Medicaid fees to Medicare fees. Physician Office and Outpatient, Physician Radiology, and Physician Surgery fees were all established at 80% of 2007 Medicare, but the average comparison percentages are currently 65.3% (physician non-facility), 77% (radiology), and 56% (non-facility, surgery).*
- *The ASC rates were developed using a Medicare methodology that is no longer in place. Rates are inconsistent in their comparison to Medicare, and do not take into account changes in the way services are delivered over the years.*
- *There is no regular rate update schedule for many fee schedules such as Physician Office and Outpatient, Speech Pathology, and Physical and Occupational Therapy; but for other fee schedules such as FQHC, Hospice, Inpatient and Outpatient Hospital, and ICF services, CMS updates fees annually, as specified in the State Plan. Connecticut Medicaid also updates rates as required by legislation (e.g., minimum wage changes for some home health services), litigation or other reasons. While some rate increases may be related to a need to improve member access, there is often not clear documentation of evidence that the specific rate increases are designed to optimally support the delivery of high value care. In some*

[64] HIPAA requires covered entities to conduct routine maintenance on medical code sets as part of the administrative simplification standards.

cases, only certain codes are updated within a fee schedule based on legislation or other specific requirements, rather than as a result of a holistic review of the entire fee schedule.

Finding 3: In some fee schedules, Connecticut Medicaid uses different service definitions and coding systems in comparison to Medicare and the comparison states and since Connecticut Medicaid has not consistently and regularly reviewed or updated fee schedules, there is no uniform explanation as to why some codes are used in place of others.

Coding systems should support the state in tracking information about utilization and services, and having multiple coding systems can make it more difficult to analyze that data. CPT codes are strictly defined, but there is room for differences across HCPCS and revenue codes. These differences are not always unexpected as states adopt codes based on the way services are delivered and use their own service definitions to describe how services are provided locally. In other cases, however, it is not clear that the differences are planned to achieve a specific objective. For example, one code within the home health fee schedule is related to medication management, considered a behavioral health service in comparison states and typically billed under a CPT code. Further, the Phase 1 study revealed that DSS uses both CPT and CDT codes for dental services, unlike other states. For CPT codes on the Psychologist fee schedule, Connecticut Medicaid in many cases defines services differently and uses different codes than do other states. The Autism Spectrum Disorder and Behavioral Health Clinician fee schedules include codes such as H0032 - Mental Health Service Plan Development, for services that are not used in the comparison states.

Finding 4: Comparisons of some services using an alternative analyses approach provide insight into rate methodologies but are limited in developing benchmarks.

The comparisons of inpatient and outpatient hospital reimbursement rates provide some insight into the level of base payments, but the actual payment methodology also includes outlier payments, graduate medical education and other add-ons, hospital supplemental payments, etc., that have not been included in the comparison because those add-ons are not comparable to the policies used by comparison states. Similarly, the alternative analyses of services such as FQHC and ICF are limited in terms of providing actual benchmarks because of the significant differences both across states and even among the different providers within each state.

Finding 5: Connecticut Medicaid generally updates methodologies and payment rates somewhat more consistently and regularly for services where fee schedules are based on providers' costs.

Error! Reference source not found. provides a detailed summary of the updates and reviews completed for the fee schedules included in this analyses**.**

Table 47: Services and Fee Schedule Methodology

Services and Fee Schedules with Methodology						
Fee Schedule	**Medicare PFS**	**Other Medicare Schedule**	**Percent %/ Medicare Fee Schedule Year**	**Cost Based/ Other**	**Rate Update**	**Discussion**
Acupuncture	X		57.5% /2021		No.	
Ambulance (Air Ambulance, Basic/ Advanced, Critical Helicopter)	--	X	--	--	2021.	Air Ambulance is manually priced. State does not have documentation regarding how other ambulance services priced.
Autism Spectrum Disorder	--	--	--	X	2021.	Increase of 4% effective 11/17/2021.
Behavioral Health Clinician, Psychologist	--	--	--	X	No.	--
Chemical Maintenance	--	--	--	X	2023.	One code was last updated in 1992 and the second in 2023.
Chiropractor	X	--	See Physician and Outpatient.	--	No.	E/M codes added to fee schedule 10/2024.
Clinic -- Ambulatory Surgical Center Services	--	X	100%/ 2007	--	No.	--
Clinic - Clinic and Outpatient Hospital Behavioral Health	X	--	--	X	No.	Codes modified between 01/2012 and 07/2024.
Clinic – Dialysis	--	X	100%/ 2007	--	No.	--
Clinic - Family Planning/Abortion	X	--	80% of 2007 Medicare for most services, 57.5% for some services, 95% for lab services.	--	2022 (codes for E/M services increased to 90% of CT Medicaid Physician OBS rate type).	--
Clinic - Medical	X	--	80%/ 2007	--	No.	--
Clinic - Rehabilitation	X	--	95% of 2008 or 2013 Medicare.	--	No.	--

Services and Fee Schedules with Methodology						
Fee Schedule	Medicare PFS	Other Medicare Schedule	Percent %/ Medicare Fee Schedule Year	Cost Based/ Other	Rate Update	Discussion
Dental Adult and Pediatric	--	--	--	X	Increases to fees for some codes.	Increases in rates 2007 for top 20 codes; decrease of 2.5% in 2015 for children's services; 25% increase in 7/1/2022 for adult endodontic services; rates for new services set at 60% of commercial rates.
FQHCs	--	--	1999/2000 base year costs, adjusted using Medicare Economic Index.	X	Annual, MEI applied to base rate.	In 2024, a $32M stabilization payment to all FQHCs; adjustments can be made based on provider request for rate adjustment to address change in scope of services.
Home Health	--	--	--	X	Annual.	Rates have been increased over the period from 2019 thru 2023 to account for minimum wage changes; rates increased 2017, 2021, for pediatric complex care and 2024 for adult complex care; VBP add-on of 1% to qualifying providers effective 2021.
Hospice	--	X	100% of Medicare.	--	Annual.	--
Hospital Outpatient	--	--	--	X	Annual.	Updates to conversion factor (based on Settlement Agreement).
Hospital Inpatient	--	--	--	X	Annual.	Updates to weights annually, base rates were updated

Services and Fee Schedules with Methodology						
Fee Schedule	**Medicare PFS**	**Other Medicare Schedule**	**Percent %/ Medicare Fee Schedule Year**	**Cost Based/ Other**	**Rate Update**	**Discussion**
						1/1/2018 based on Settlement Agreement. Updates for wage index and Indirect Medical Education. Rehab/BH DRGs paid using per diems are updated 2% annually.
Independent Audiology and Speech and Language Pathology	X	--	1986 / 2000; exact date not documented.	--	No.	Changes in 2015 to account for change in daily quantity limits allowed for reimbursement.
Independent Physical Therapy and Occupational Therapy	X	--	1999; exact date not documented.	--	No.	--
Independent Radiology	X	--	57.5%/ 2007.	--	No.	--
Intermediate Care Facility (Private)		--	--	X	Annual.	--
Laboratory Services	X	--	70% / 2015	--	No.	--
MEDS-DME	--	X	85% / 2007	--	No, except to implement Cures Act limits 2018.	New codes paid at 85% of current Medicare.
MEDS-Hearing Aid/Prosthetic Eye	--	X	85% / 2007	--	No.	--
MEDS-Medical Surgical Supplies	--	X	85% / 2007	--	No.	--
MEDS – Enteral/ Parenteral	--	X	85% / 2007	--	No.	--
MEDS – Prosthetic / Orthotic	--	X	90% of the Physician Fee Schedule determined as (85% / 2007).	--	No.	--
Naturopath	X	--	90% of CT Physician Fee Schedule	--	No.	Codes modified 01/2012.

Services and Fee Schedules with Methodology						
Fee Schedule	Medicare PFS	Other Medicare Schedule	Percent %/ Medicare Fee Schedule Year	Cost Based/ Other	Rate Update	Discussion
			(85% / 2007 Medicare).			
Nursing Facility Services	--	--	--	X	Quarterly case-mix adjustment.	2019 cost reports, rebased every 2-4 years, quarterly case mix adjustment.
Optician/Eyeglasses	--	--	--	X	No.	2008 rate adjustment; state uses a Vision Care Volume Purchase Contractor.
Physician Anesthesiology	X	X	57.5% /2007	--	--	New codes priced at 57.5% of current Medicare PFS.
Physician Office and Outpatient Services/HUSKY Primary Care/Psychiatrists	X	--	57.5% / 2007 Obstetrics: 145%/2007 Psychiatrists: 100%/2007. HUSKY Health: certain fee schedules rates increased.	--	No.	New codes priced at 57.5% of current Medicare PFS; Primary Care rates updated 2013 based on Affordable Care Act requirements.
Physician Radiology	X	X	57.5% / 2007 and 100% / 2007 for OBS radiologists.	--	No.	New codes priced at 57.5% of current Medicare PFS.
Physician Surgical	X	X	57.5% / 2007 and 145% / 2007 for OBS.	--	No.	New codes priced at 57.5% of current Medicare PFS.
Psychiatric Residential Treatment Facilities (Private)	--	--	--	X	2023.	Rate increase to add DON staffing; rates negotiated based on Annual Cost Reports.

Finding 6: Connecticut Medicaid has established multiple fee schedules for groups of providers that are generally included in one overall fee schedule in the comparison states and Medicare.

The Medicare Physician Office and Outpatient fee schedule and comparison states' fee schedules group most physician and outpatient services into a single fee schedule. Connecticut Medicaid, in contrast, has different fee schedules for Chiropractors, Psychologists, Surgeons, Radiologists, etc. Services such as evaluation and management visits appear across the various fee schedules. Multiple fee schedules are more burdensome to administer and make it more difficult to identify where inconsistencies exist, for example, where the same codes appear on two fee schedules with different rates. Those rate differences may have been implemented to fulfill specific policy objectives, but without documentation in some cases, it is not possible to confirm the rationale for such differences.

There are also examples of fee schedules where similar services appear on different fee schedules but have different codes and different rates. The Phase 1 work indicated that adaptive behavior treatment is billed using two separate codes, one on the Autism Spectrum Disorder fee schedule and another on the Behavioral Health Clinician fee schedule. Each code has a different rate although the underlying provider qualifications and the services provided may be nearly identical. Different codes and rates for the same service create potential inequity in payment rates across providers.

To provide an illustrative example, Myers and Stauffer conducted an analysis of 20 procedure codes with the highest number of occurrences of different rate types/fee schedules (these codes appear on from 4 to 6 different fee schedules) and compared the rates across the various fee schedules. *Table 48* summarizes those procedure codes. For some codes, for example, H0031, rates are fairly consistent across fee schedules (70 – 74% of the rates on the Physician and Outpatient fee schedule at the minimum, average, median, and maximum). For other codes, for example, 99214, percentages vary from 90 – 220% at the minimum, average, median, and maximum). These findings indicate that fee schedules lack consistency and do not necessarily reflect policy decisions made by DSS.

Table 48: Procedure Codes on Multiple Fee Schedules

Procedure Codes Contained on the Most Number of Connecticut Fee Schedules						
Procedure Code	Number of Fee Schedules Where A Code is Listed	Number of Rate Type/Fee Schedule Combinations	Percent Comparison To Physician Rates[65]			
			Non-Facility Rate Types			
			Min	Avg	Median	Max
99202 - New Patient (Straightforward)	6	11	90%	158%	177%	220%
99203 - New Patient (Low Level)	6	11	90%	157%	173%	220%
99204 - New Patient (Moderate Level)	6	11	90%	158%	176%	220%
99205 - New Patient (High Level)	6	11	90%	158%	175%	220%
99211 - Established Patient (Straightforward)	6	11	90%	145%	144%	220%

[65] The "Physician Rate" used for comparison purposes is the Physician Office rate. For the procedure codes above, with the exception of codes 97158 and H0031, there are additional facility-based rates.

99212 - Established Patient (Straightforward)	6	11	90%	157%	174%	220%
99213 - Established Patient (Low Level)	6	11	90%	160%	181%	220%
99214 - Established Patient (Moderate Level)	5	10	90%	165%	176%	220%
99215 - Established Patient (High Level)	5	10	90%	164%	174%	220%
90791 - Psychiatric diagnostic evaluation	4	10	35%	81%	88%	99%
90832 - Psychotherapy 30 min	4	9	67%	92%	87%	114%
90834 - Psychotherapy 45 min	4	9	66%	86%	83%	103%
90837 - Psychotherapy 1 hour	4	9	65%	86%	83%	103%
90846 - Family psychotherapy w/o patient 50 min	4	9	65%	93%	92%	127%
90847 - Family psychotherapy with patient 50 min	4	9	65%	87%	84%	106%
90853 - Group psychotherapy	4	9	73%	85%	85%	101%
99406 - Smoking and tobacco use intensive counseling 4-10 min	4	9	73%	144%	146%	204%
99407 - Smoking and tobacco use intensive counseling > 10 min	4	9	73%	108%	100%	147%
97158 - Adaptive behavior treatment by professional with group	4	9	69%	73%	72%	88%
H0031 - Mental health assessment by non-physician	4	9	70%	74%	73%	88%

Finding 7: The review of the procedure codes and fees overall indicated there was no utilization of services for many codes in 2023.

There are a number of fee schedules where a relatively large proportion of total codes have no utilization. It is not possible to determine from the analyses conducted from the rate study if codes without utilization should be deleted, if codes are no longer being used because they have been replaced in practice by new codes and the providers are selecting not to bill some of the older codes, or whether codes are not being reported because there are access or billing issues associated with those codes. For example, there are 21 codes for knee/foot orthosis, but nearly all the utilization is in a single code with only a few claims in 4 other codes. That could be a reflection of customary practice as industry and the needs of members change or it could reflect access issues related to a particular service.

Finding 8: DSS' medical administrative services organization monitors access to services using geo-mapping and other tools, and also reviews complaints regarding member access.

DSS staff report access issues related to certain specialties and certain groups of services but acknowledge that access in some cases is not necessarily a fee schedule sufficiency issue. For example, there is a shortage of dermatologists across the state for all individuals, not just Medicaid. Some

pediatricians have raised concerns about their rates. There have been difficulties in accessing the services of ear, nose, and throat specialists. However, DSS staff indicate that they have been successful in resolving individual access issues.[66]

Finding 9: DSS has numerous ad-hoc initiatives that are in process to address specific needs but have not yet established a process for systematic and routine updates across all program areas.

Examples of ongoing initiatives include:

- *DSS has implemented a quality incentive feature in its nursing facility payment methodology and is currently collecting data from nursing facilities to establish a baseline for quality indicators; upon full implementation of the program and subject to available state appropriation and federal approval, some providers may be eligible for additional payments.*
- *Effective January 1, 2025, DSS is implementing a bundled payment methodology for maternity services, which will provide eligible providers a case rate and shared savings payments to improve incentives for improving quality outcomes and containing unnecessary costs.*
- *Effective January 1, 2025, DSS is implementing enhanced value-based payment (VBP) for pediatric inpatient hospital psychiatric services designed to improve outcomes and contain unnecessary costs and building upon existing financial incentives to improve access to and quality of pediatric inpatient psychiatric services.*
- *Connecticut is one of several states that applied for and received a federal grant from the Center for Medicare and Medicaid Innovation (CMMI) within CMS for the States Advancing All-Payer Approaches to Health Equity Approaches and Development (AHEAD) Model, under which DSS, in collaboration with the state Office of Health Strategy (OHS) and other partner agencies, is developing two significant changes in Medicaid payment methodology slated for launch effective January 1, 2027: a global budget payment methodology for hospitals that choose to participate and improvements to the state's primary care alternative payment methodology, building upon the shared savings and quality incentives included in the state's current person-centered medical home (PCMH) and person-centered medical home plus (PCMH+) payment models for eligible primary care providers/entities.*
- *DSS is continuing to implement targeted value-based payment for eligible home and community-based services (HCBS) providers as currently funded through section 9817 of the federal American Rescue Plan Act (ARPA), designed to improve quality and equity of HCBS services. Key components of these VBP payments are intended to continue after the reinvestment period covered by section 9817 of ARPA.*
- *Connecticut recently applied for a planning grant from the federal Substance Abuse and Mental Health Administration (SAMHSA) to explore the possible development of Certified*

[66] Myers and Stauffer discussions with DSS, October 2024.

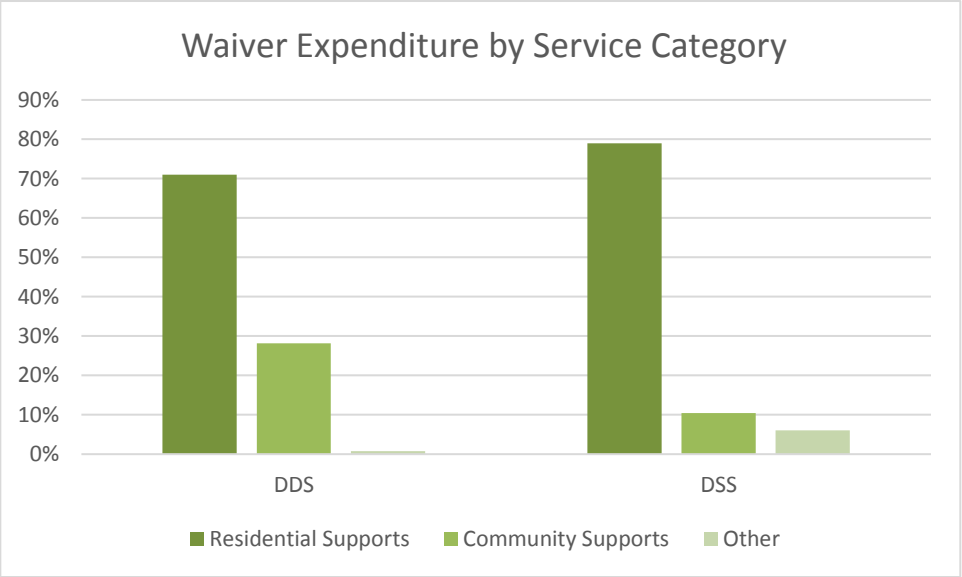
Community Behavioral Health Clinics (CCBHCs), which is a set of possible alternative payment methodologies for eligible behavioral health clinics.

Included in Appendix D is the HCBS Rate Study. The following findings were included in that report and are excerpted here:

Finding 10: Average waiver costs are higher in Connecticut than in neighboring states and service utilization occurs predominantly in residential supports. In both waivers systems (those operated by DSS and DDS), expenditures associated with residential supports comprise more than 70% of total expenditures.[67]

DDS system waiver expenditures in services designed to support community integration comprised less than one third (28%) of the expenditures in these two waiver systems. While not unusual in waivers serving older members, waivers serving adults with physical and/or intellectual or developmental disabilities generally show a greater investment in community supports and integration. *Figure 8* below shows the breakdown of residential and community supports in each of the two waiver systems.

Figure 8: Waiver Expenditure by Service Category

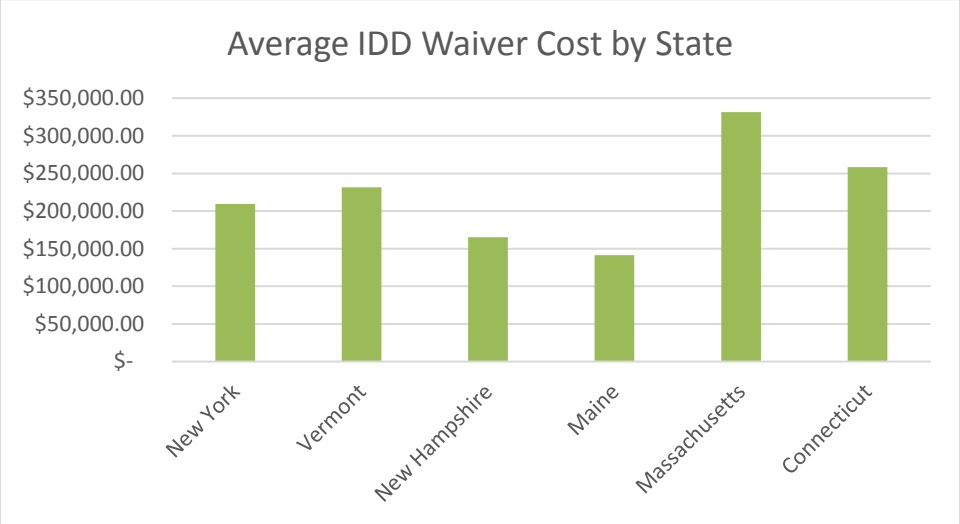


In addition, waiver expenditures overall in Connecticut are higher than both the national average and the average of neighboring states' waiver expenditures. The University of Minnesota Residential Information Systems Project (RISP) has compiled waiver costs for all states for waivers supporting

[67] Based on expenditure data collected and modeled during this rate study.

individuals with intellectual and developmental disabilities (IDD).[68] The RISP study collected data for 30 years and while it concluded 4 years ago, using the final report and comparing Connecticut to neighboring states demonstrated that average per persons costs were higher in Connecticut than in all but one neighboring state (Massachusetts). The 2020 RISP profile listed the average IDD waiver cost in northeastern states in 2020 is $215,780; for that same period Connecticut's average cost was $252,282. *Figure 9* provides a breakdown of average cost by neighboring state as reported in the RISP database.

Figure 9: Average IDD Waiver Cost by State



Utilizing this data, the average IDD waiver cost in northeastern states is $215,780, in the same period of the study Connecticut's average cost was $252,282.

Finding 11: Waiver eligibility and service planning do not currently employ a standardized, evidence-based assessment tool to aid in person centered planning.

Standardized assessments that are appropriately validated against the population of participating members is a best practice in waiver management. Standardized assessments are designed to measure functional level, identify strengths and areas of needed support, and establish the availability of natural supports. All these elements can provide critical information for identifying needs for supports as well as establishing thresholds to trigger tiered rates based on acuity or need. Accordingly, the HCBS quality measures examine the use of functional assessments in the delivery of HCBS services as a core indicator of quality care.[69]

[68] https://risp.umn.edu/about/overview
[69] https://www.medicaid.gov/federal-policy-guidance/downloads/smd22003.pdf

Recommendations Regarding Rebasing and Updating Fee Schedules

Based on the findings related to the rate comparisons and development of benchmarks, Myers and Stauffer makes the following recommendations.

Recommendation 1: Use Medicare as the benchmark for fee schedules and update those fee schedules periodically and to a more current year.

Medicare can serve as a rational basis for benchmarking and updating rates, and DSS has used the Medicare approach for many of the fee schedules included in this study. CMS invests heavily in the development of Medicare rates for most services covered by Medicare. The analysis of codes and fees for this report showed that 51% of the benchmarked codes had a Medicare comparison point. However, many fee schedules have not been updated to reflect how services are currently delivered and to take advantage of the work that CMS has done with regard to those fee schedule rates. The Physician Office and Outpatient fee schedule, other Physician fee schedules, and the fee schedule for ASC services provide examples of fee schedules that are not aligned with current Medicare approaches.

Recommendation 2: Create greater provider equity by rebasing the fee schedules using a consistent percentage of the current Medicare Physician Fee Schedule (PFS) or other relevant Medicare fee schedule.

Where DSS determines that the percentage of Medicare should be different for a particular set of services within a fee schedule, either based on physician or practitioner specialty or type of service, DSS should document the rationale and decision making regarding those differences and make further updates that reflect these decisions. These differences are, in many cases, not currently related to specific policy goals, and rebasing will allow DSS to make sound policy decisions regarding if and by how much rates should be adjusted from a standard percent of Medicare rates. Using consistent percentages of the Medicare rates to maintain fee schedule rates can also reduce the need to maintain separate fee schedules for specific categories of providers.

Recommendation 3: Develop a timetable for the review and/or update of rates, and for rebasing rates to achieve greater equity across providers. Update rates each year to maintain a consistent percentage of Medicare rates as those rates are updated each year.

At least every 3 to 5 years, DSS should rebase fees, i.e., use a more current Medicare base year and provide an increase in rates to the extent necessary to rebase rates for all codes on the applicable fee schedule to a consistent percentage of the current Medicare rates. Maintaining consistent updates in

accordance with CMS updates can allow the state to maintain competitive rates without requiring significant updates to individual providers when they lag behind for many years. More consistent rate changes that reflect the current environment are more sustainable and predictable for providers, and less likely to result in significant inequitable rate increases for some providers at the expense of others.

Recommendation 4: For rates where Medicare does not provide a methodologically sound approach for updating rates, update rates using other state Medicaid programs' rates initially, and adopt independent rate models in future years.

Some service types are not covered by Medicare and will not have a Medicare fee schedule to use as a basis. For example, waiver services are not covered by Medicare. For fee schedules where DSS has significant expenditures, DSS can begin rebasing rates using an independent rate model where rates are built from the ground up based on any of, or combination of, available cost component information (e.g., wage information from the Bureau of Labor Statistics, publicly available inflation indices, and other market data). Cost surveys can also be used to provide data for rate development. A rate model should be documented for re-use and transparency and to support ongoing management and updating of rates. At the time of rebasing, DSS should examine service definitions so that they accurately reflect each service as it is provided currently. Service definitions, as well as provider qualifications, may change as new evidence-based models are created, clinical recommendations change over time, and practitioner categories change over time, which may include the creation of new specialists or provider types.

For fee schedules such as Family Planning that are not covered by Medicare but have reasonable matches to the Five-State Average rate, DSS can begin by initially increasing rates up to the Five-State Average rate. DSS may then consider using that as an ongoing benchmark for future updates or utilize an inflationary measure to increase rates on a predictable schedule.

DSS should rebase rates every five years with updated cost and market information and review rates midway through the rate period, applying an inflation factor as possible to maintain consistency of fee schedules with base information. Given the administrative and financial resources necessary to conduct this type of rate setting process, the recommendation is to update rates less frequently than every 3 to 5 years for services where there are Medicare equivalents.

Recommendation 5: Consider rebalancing, i.e., revising services that are included on a particular fee schedule, or shifting greater payments to some services while decreasing payments for other services, to further state policy and program goals.

Over time, some codes are used to serve state-specific program goals. For example, two home health codes that are particularly vital to the delivery of community-based mental health services are included in the Home Health fee schedule. While the service and provider type are clinically appropriate for coverage, inclusion in the Home Health fee schedule does not allow for a transparent review of the full

investment in behavioral health services and creates a single Home Health code that does not compare to the codes used by other states. Regrouping this code to one of the Behavioral Health fee schedules would allow it to be viewed in context of rates for other behavioral health services. Regrouping would not require a change to the service or the provider qualifications but would better reflect the behavioral health continuum of services. Similarly, other fee schedules, such as the Autism Spectrum Disorder fee schedule, could benefit from a fee schedule rebalancing to better align fees and codes that represent DSS priorities, shifting greater payment to some services and reduced payment to other services. Rebalancing can help to retarget funding to attract and retain healthcare providers and promote access to care for members.

Recommendation 6: For rate methodologies that were analyzed using an alternative approach, continue the rate updates and rebasing as currently completed to maintain the integrity of the methodologies and resulting fee schedules.

The analysis of rate methodologies using an alternative approach indicated that, for a number of services, rates are provider specific and updated regularly. The approach to updating rates annually for FQHCs is in federal regulations as are rates for Hospice services; rates for ICFs, nursing facilities and PRTFs are updated regularly. These practices should continue.

Recommendation 7: Combine all the fee schedules paid using the Medicare Physician Fee Schedule (PFS) into one fee schedule and do the same for the Connecticut Medicaid fee schedules that are based on the Medicare DMEPOS fee schedule.

The current fee schedules are organized using rate types, which is not an organizational system supported within the current claims system. Having codes duplicated across fee schedules (for example, 99202 New Patient Visit) also increases the chance that a rate for a code for one specialty provider is updated while the same code for other specialty providers is not, leaving fees for some specialists lagging in terms of updates. This recommendation also addresses the issue of different rates for the same services that occur because the same codes are on different fee schedules.

Recommendation 8: Continue to monitor access to services as fee schedule methodologies and rates are changed to make certain access issues do not arise.

DSS reviews any issues related to access that may be identified by the medical administrative services organization and noted no access concerns currently. As DSS changes methodologies and rates, including rebalancing of fees, DSS should specifically monitor access to those services affected by the changes, determine if there are unanticipated access issues that arise, and make further modifications to fee schedules to address those.

Recommendation 9: Consider expanding the implementation of various types of alternative payment methods for different categories of providers selected by DSS that include incentives to providers to

improve the quality and overall value of services provided to members, including improving cost containment.

Alternative payment methodologies for various provider types can provide quality incentives to tie financial investment to health care outcomes. The quality incentive programs used by states vary in their complexity, but consideration should be given to the administrative requirements for quality programs. If DSS is interested in pursuing such options, it should identify the data and reporting requirements needed to support the approaches, and begin planning for implementation, to include data gathering and other tasks.

- *As referenced above, currently, there is a quality incentive program associated with the nursing facility methodology and DSS is in the process of collecting information.*
- *As referenced above, effective January 1, 2025, DSS will begin implementing a bundled payment for maternity services.*
- *As referenced above, effective January 1, 2025, DSS will begin implementing updated value-based payment for pediatric inpatient psychiatric services.*
- *As referenced above, DSS is participating in the federal AHEAD model grant slated for implementation January 1, 2027, which will implement a hospital global budget payment methodology for participating hospitals with an update to the primary care value-based payment, which is currently implemented through the state's PCMH and PCMH+ programs.*
- *As referenced above, DSS is using targeted value-based payments to improve HCBS as funded through section 9817 of ARPA.*
- *As referenced above, DSS applied for a planning grant to explore the potential development of a CCBHC model.*
- *The development of an APM for FQHC services presents an opportunity to implement a quality initiative program that can provide incentives for improved care coordination, member experience, and cost containment.*
- *DSS is exploring other potential alternative payment models to improve the value of services provided to Connecticut Medicaid members, such as an Accountable Care Organization (ACO) or similar model that would likely build upon the foundation of PCMH and PCMH+, with a broader focus and consistent with the development that will occur through Primary Care AHEAD.*

Appendix D includes additional recommendations specifically for HCBS. They are:

Recommendation 10: DSS should examine the current HCBS array, including the utilization of services and service descriptions, to determine if the policies that drive utilization in the waiver programs reflect the program goals, including providing for greater opportunity for community integration.

DSS may wish to identify the population-based goals for each waiver and identify procedures and administrative models to support these goals.

Recommendation 11: DSS should identify the population-based goals for each waiver and identify procedures and administrative models to support these goals.

Recommendation 12: DSS should examine the current process for assessing waiver members and consider adoption of standardized and validated tools that could provide a comprehensive assessment of functional needs, natural supports, and level of acuity.

DSS should also examine the program policies and procedures to align them with best practices such as assessment-supported person-centered planning. These actions may also help Connecticut to comply with the HCBS quality measures and provide for greater quality monitoring.

Following this report, Myers and Stauffer will work with DSS to develop a detailed roadmap that provides strategies and key steps, milestones, and timeline needed to achieve a rational approach to updating rates.

Appendix B

Description of Adjustments Made to Data Used for Comparison of Fee Schedules and Budget Impact Assessment

For each of the service categories/fee schedules/service areas, the following tasks were conducted.

1. Codes from each fee schedule were listed and grouped into provider type and specialty description for comparison purposes. Connecticut uses a rate type to organize fee schedules that represents a combination of service, provider type description, and provider specialty description. The services analyzed fall into the following groupings, as shown in *Table 49*:

Table 49: Fee Schedule Groupings for Conventional Rate Comparison

Fee Schedule Groupings for Conventional Rate Comparison		
Phase 2 Service	**Provider Type Description**	**Provider Specialty Description**
Acupuncture	• Acupuncturist • Acupuncturist Group	• Acupuncturist
Ambulatory Surgical Services	• Clinic	• Ambulatory Surgical Center
Audiology and Speech	• Therapist • Therapist Group	• Audiologist Therapist • Speech Therapist
Chemical Maintenance	• Clinic	• Methadone Clinic
Chiropractor	• Chiropractor • Chiropractor Group	• Chiropractor
Clinic and Outpatient Hospital Behavioral Health	• Clinic	• Behavioral Health Clinic • Enhanced Care Clinic (ECC)
Clinic - Medical	• Clinic	• Medical Clinic • School Based Health Clinic
Clinic - Rehab	• Clinic	• Rehabilitation Facility
Dialysis (Non-Drug Codes)	• Clinic	• Free-standing Renal Dialysis Clinic
DME	• DME/Medical Supply Dealer	• Limited to procedure codes E0100 – E8002 and K0001 – K1033
Clinic - Family Planning	• Clinic	• Family Planning Clinic
Hearing Aid and Prosthetic Eye	• DME/Medical Supply Dealer	• Limited to procedure codes V2623 - V5298
Home Health (HCPCS Codes)	• Home Health Agency	• Home Health Agency
Independent Radiology	• Radiology	• Portable Radiology • Non-Portable Radiology
Laboratory	• Laboratory	• Independent Lab
Medical Surgical Supplies	• DME/Medical Supply Dealer	• Limited to procedure codes A4216 - A9999 and T4521 - T4544
MEDS-Enteral/Parenteral	• DME/Medical Supply Dealer	• Limited to procedure codes B4034 - B9999

Fee Schedule Groupings for Conventional Rate Comparison		
Phase 2 Service	**Provider Type Description**	**Provider Specialty Description**
MEDS-Misc	• DME/Medical Supply Dealer	• Limited to procedure codes 90589, 90623, 90678, 90679, S1040, S9432, and S9435.
Naturopath	• Naturopath • Naturopath Group	• Naturopath
Optician and Eyeglasses	• Optician • Optician Group/Optical Shop	• Optician
Physical and Occupational Therapy	• Therapist • Therapist Group	• Physical Therapist • Occupational Therapist
MEDS - Prosthetic/Orthotic	• DME/Medical Supply Dealer	• Orthotic And Prosthetic Devices
Psychiatric Residential Treatment Facility (PRTF) – Private	• Special Services	• Psy Res Trmt Fac
Emergency Transportation	• Transportation Provider	• Ambulance • Air Ambulance • Critical Care Helicopter

2. A listing of paid claims was obtained for each code and the number of units of services identified for each code. DSS generated a report of claims incurred and paid during CY 2023 for the select providers and fee schedules. Claims listed were fully adjudicated (i.e., if a claim was revised subsequent to processing, the original claim was removed). Units for Medicare crossover claims, which are claims for people eligible for both Medicare and Medicaid and where Medicare paid most of the claim and Connecticut Medicaid paid only the covered amounts that Medicare did not pay, were also removed.
3. Units for codes for which it was not possible to make a comparison of rates were further identified and removed. About 34.34 million units and associated payments totaling approximately $239 million were removed. Whenever there was only one rate type for a unique code and modifier combination, Myers and Stauffer used code and modifier to match claims units with the fee schedule rate. Because the claims data does not include rate type information, claims could not be assigned to a specific rate type. For Physical Therapy and Occupational Therapy, Myers and Stauffer was able to identify the rate type by provider specialty. For Clinic and Outpatient Hospital Behavioral Health, Enhanced Care Clinic and Outpatient Enhanced Care Clinic were grouped together when the rates were identical. Similarly, Mental Health Clinic and Outpatient Mental Health were grouped together when the rates were identical. Wherever a code and modifier combination was associated with multiple rate types in the fee schedule and the fee schedule rate was identical, Myers and Stauffer allocated 100% of the units for the code and modifier combination to one rate type.
4. Rates of selected states and Medicare were identified based on the most recent publicly available information regarding fee schedules from Medicare and the sample of other states.

Connecticut Medicaid rates, other state Medicaid rates, and Medicare rates are from fee schedules in effect on January 1, 2024. Therefore, this Phase 2 of the rate study does not include any rate changes that occurred during CY 2024, including the specific rate increases that were implemented effective July 1, 2024, for emergency ambulance, chemical maintenance clinic, and children's behavioral health services.

5. The average of five-state rates (referred to as the Five-State Average rate) were determined and the Medicare rate is a single point. In some cases, there may have been fewer than five comparison points if the code was not utilized in all five states or Medicare.
6. Any rate comparisons from the Five-State Average were removed when there were not at least two comparisons.
7. For Home Health services, Connecticut uses a combination of HCPCS codes and revenue center codes to report services. The comparison states also use either HCPCS codes and/or revenue codes to report home health services. Even though services may be reported with the same codes, the unit of service measure may not be directly comparable. For example, some home health services may be reimbursed on a per-visit basis, while others are based on units of time, such as 15-minute increments.
8. For services where the unit of measure differed but still allowed for a comparative rate analysis to be performed, the other state's rate was converted to match Connecticut's units of measure (e.g., converting a 15-minute rate to a 1-hour rate by multiplying it by four). For example, the CT code S9123 (RN services in home by Registered Nurse, per hour) is not used for home health services in Massachusetts. However, the code G0299 (Services of skilled nurse (RN) in home health setting, 15 minutes) is a similar code with a unit of measure that can be converted into an hourly rate.
9. For codes where an exact 1:1 code match did not exist, provider requirements, policy materials, and service description information was used to identify codes that closely matched the Connecticut Medicaid codes. This more frequently happens for services that use more HCPCS codes to reflect services as they are provided in that specific state. Maine, Massachusetts, and Oregon use HCPCS codes for home health services that either matched exactly with Connecticut's codes or had a comparable code that could be used. For example, New Jersey, New York, and Oregon use revenue center codes that matched with the Connecticut codes for Home Health services.
10. Outliers (i.e., those comparisons where the Connecticut Medicaid rate as a percent of the comparison rate was extraordinarily high or low) were examined. Outliers occurred for a number of reasons, such as the other state rates appeared invalid (e.g., $.01 per unit). These codes appear as unmatched codes in the analysis.

11. The analyses as presented in each of the fee schedule summaries was conducted by calculating the difference to the comparison points and identifying the fiscal impact.

Appendix C Alternative Payment Models

Introduction

DSS requested that Myers and Stauffer, as part of the Rate Reimbursement Project, identify service areas that would benefit from improved quality, improved access, and higher quality care for members, and specifically identified federally qualified health centers and nursing facilities for study. The objective of this review was to determine how payment structures have been designed to incent providers to deliver high quality care, equity of care, and improved access to members. DSS also requested that the analysis provide outcomes information from those programs where such information is available.

General Alternative Payment Model Options

Some state Medicaid programs use various types of alternative payment models that include various types of providers:

- *Minnesota and Vermont use Accountable Care Organizations (ACOs).[70] ACOs may be linked to one or more APMs and accountable for quality or cost-savings. Statewide measures and targets related to the health of the population are developed consistent with the priority areas, regardless of whether the population seeks care at the providers in the ACO.*
- *Maryland and Pennsylvania have global budgets for hospitals and those models served as part of the impetus for the CMMI AHEAD model, in which Connecticut is participating, as referenced above. Predetermined payment amounts are made to a group of providers or a health system (such as a group of health care organizations like hospitals) covering most or all of a patient's care across providers during a specified time period.[71]*
- *Colorado, Ohio and Tennessee use episode-based payments/bundled payment models that hold providers accountable for a total budget that covers all the services within an or episode of care, including specialists.*

[70] https://gmcboard.vermont.gov/content/APM/AboutTheAPM, https://mn.gov/DSS/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/integrated-health-partnerships/

[71] https://hscrc.maryland.gov/Pages/tcocmodel.asp, https://www.pa.gov/en/agencies/health/facilities/in-patient-healthcare-facilities/hospitals/rural-health-model.html

Examples of FQHC Alternative Payment Models in Other State Medicaid Programs

There are various types of alternative payment models for FQHCs in different states. In some states, Medicaid managed care organizations may have incentive programs targeted for FQHCs. There are also various types of APMs for FQHCs, some examples of which are listed below.

Table 50 summarizes some key features of incentive-based payment arrangements targeted specifically at FQHCs and paid through APMs.

Table 50: Examples of State APMs that Include Incentive Payment Approaches

Examples of State APMs that Include Incentive Payment Approaches			
State	**Incentive Approach Methodology**	**Quality Metrics**	**Outcomes**
California [72]	Scheduled to go-live in January 2025. A per member per month (PMPM) rate will be paid for each assigned member from a contracted managed care plan. The actuarially equivalent amount is projected PPS payments for base year utilization. This approach enables FQHCs to reduce traditional (billable) visits and increase alternative services (not billable) without reducing revenue. Pay-for-transformation funding will equal the historic FQHC encounter utilization priced at the current PPS minus the current encounter utilization priced at the current PPS. An FQHC can increase the size of the pay-for-transformation	FQHCs must meet a minimum performance threshold for participation. The Department of Health Care Services (DHCS) will initiate corrective action if a participating FQHC does not maintain one or more of these thresholds. Access Measures: • FQHC must maintain a floor of 70% PPS visits (sum of PPS visits and alternative care services) to maintain participation in the APM Quality Measures: • Maintain baseline for the Well Child Visits in the first 30 months, Child and Adolescent Well-Care Visits, Adults' Access to Preventive/Ambulatory Health Services, Aggregated Quality Factor Score (AQFS; calculated from all reported measures). If the FQHC does not maintain either the minimum access	Not yet implemented. The APM is intended to align with and support DHCS' quality strategy, including: • Eliminating health disparities through anti-racism and community-based partnerships. • Data driven improvements that address the whole person. • Transparency, accountability, and member involvement.

[72] https://www.dhcs.ca.gov/services/Documents/DirectedPymts/FQHC-APM-Program-Guide.pdf, https://www.dhcs.ca.gov/services/Documents/DirectedPymts/FQHC-APM-September-2022-Overview.pdf

Examples of State APMs that Include Incentive Payment Approaches			
State	**Incentive Approach Methodology**	**Quality Metrics**	**Outcomes**
	funding by improving its efficiency (e.g., decreasing costs) while maintaining the quality and access to care for its members. DHCS notes that the FQHC will require significant new investments in care management capabilities, infrastructure, information technology and data exchange, and workforce capacity at both the managed care organization and FQHC levels. FQHCs will be permitted to retain "Pay for Transformation Payment" or "the wedge," which refers to the difference in reimbursement an FQHC would receive under an APM PMPM and what the FQHC would have received under PPS, assuming traditional PPS-reimbursable encounters decline. FQHCs participating in the APM must develop and implement practice transformation plans, provide complete encounter data to the managed care organizations, meet quality and access metrics, and submit data required for managed care organizations to calculate performance metrics.	threshold or has degradation of 5% or more of the Quality Measures, a Corrective Action Plan would be triggered. If scores do not return to the baseline measures after 12 months, the FQHC may face a 5% penalty or may be removed from the program.	

Examples of State APMs that Include Incentive Payment Approaches			
State	**Incentive Approach Methodology**	**Quality Metrics**	**Outcomes**
New York[73]	As its APM, FQHCs can participate in the APG methodology. The APG methodology provides an opportunity to bill for certain primary care enhancements that are built into rates, such as diabetes, asthma education, and expanded hour access. Eligible FQHCs can also receive an additional payment to preserve and improve beneficiary access to care and avoid loss of services in areas of concern. The annual amount of the additional payment will not be subject to subsequent adjustment or reconciliation.	N/A	N/A
North Carolina[74]	New FQHC APM based on prospective rates (approximately 113% of allowable costs) to be implemented. [75] Two enhanced payments are also available to FQHCs that are serving as a Pregnancy Management Program (PMP): • Upon completion of the high-risk	Separately, PMP providers and care coordinators have established statewide standards to reduce unnecessary care variation around pregnancy hypertension, preterm labor prevention, induction standards for first-time moms, perinatal tobacco use, substance use in pregnancy, multi-fetal pregnancy, postpartum well care, and reproductive life planning	State has reported improvements in some key outcomes for the overall Pregnancy Management Program, but results are not available for only FQHC performance.

[73] The APG methodology is a classification system that pays the facility's cost of care. The basis of reimbursement is the categorization of the contact between the patient and health care provider. The contact could be categorized as either a procedure, a medical evaluation and management, or an ancillary service. For each interaction, a prospective weight and price is established that includes routine services associated with the visit and/or procedure. Source: https://www.health.ny.gov/health_care/medicaid/rates/manual/docs/apg_provider_manual_december.pdf

[74] https://medicaid.ncdhhs.gov/providers/fee-schedules/pregnancy-medical-home-fee-schedules#:~:text=Effective%20July%201%2C%202021%2C%20the,rates%20effective%20July%201%2C%202021

[75] https://medicaid.ncdhhs.gov/blog/2024/07/17/updated-federally-qualified-health-centers-and-rural-health-clinics-reimbursement-methodology

Examples of State APMs that Include Incentive Payment Approaches			
State	**Incentive Approach Methodology**	**Quality Metrics**	**Outcomes**
	screening, an enhanced payment of $52.50 will be made to the FQHC • Upon completion of the recipient's post-partum visit, an enhanced payment of $157.50 will be made to the PMH provider.	Enhanced payments for screenings and postpartum visits.	
Ohio[76] [77]	Statewide managed care; MCOs are subject to a quality withhold linked to MCO performance. Through the Comprehensive Primary Care (CPC) Program, FQHCs can receive supplemental PMPM payments and shared savings. Practices must • Meet "Activity Requirements" and "pass" 50% of the 25 clinical quality and efficiency measures, and • Meet total cost of care (TCoC) targets or improve their performance on TCoC targets from the baseline year. TCoC excludes some services (waiver services, oral health, vision, transportation; long-	"Activity Requirements" focus on service delivery changes, such as supporting 24/7 access to care, risk stratification, population health management, and use of team-based care models.	Results for FQHCs only not available, only total CPC savings.

[76] https://nashp.org/wp-content/uploads/2018/05/Toolkit-State-Strategies-to-Develop-Value-Based-Alternative-Payment-Methodologies-for-FQHCs.pdf
[77] https://www.medicaid.gov/medicaid/spa/downloads/OH-24-0007.pdf

Examples of State APMs that Include Incentive Payment Approaches			
State	**Incentive Approach Methodology**	**Quality Metrics**	**Outcomes**
	term care costs after 90 days).		
Oregon[78]	All-inclusive PPS rate that aligns payment for Health Centers with high quality, efficient provision of patient-centered health care in order to incentivize high-value services over a volume of visits. The participating parties understand that the program is intended to incent a significant transition in patient-centered care and that it will likely result in a reduction in traditional, billable patient visits. At the same time, the program will likely result in an increase in nonbillable engagement with the patient known as Care STEPs (Services that Engage Patients) The Advanced Payment and Care Model (APCM) makes payments on a PMPM basis. APMs let practices earn more rewards in exchange for taking on risk related to patient outcomes. The program is intended to incent a significant transition in patient-	OHA tracks five metrics on a quarterly basis • Colorectal Cancer Screening • Depression Screening • Diabetes Poor Control • Weight Assessment and Counseling in Children and Adolescents • Hypertension	OHA reported: • Significant and measurable increases in Care STEPs. • Nearly 90% of APCM clinics expanded care teams. • Improvements in quality metric performance.[79] The 2023 Annual Report of the Oregon Primary Care Association reported: • APCM clinics saved a net of $17 million through a reduction in hospital utilization among attributed populations. Moving to population health payment enabled countless local level clinical and community health innovations. • Nearly 90% of APCM clinics expanded care teams as a result of participating in APCM, and patient engagement with care teams beyond traditional visits more than tripled since 2013.[80]

[78] https://www.nachc.org/wp-content/uploads/2023/03/Oregon-FQHC-APM-December-2017.pdf; https://www.oregon.gov/oha/HSD/OHP/Tools/APM%20FAQs.pdf; https://www.oregon.gov/oha/HSD/Medicaid-Policy/StatePlans/Medicaid-State-Plan.pdf, https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1733

[79] https://www.ohsu.edu/sites/default/files/2023-10/16.00%20Roller%20and%20Cooke%202023%2010%2005%20APCM%20RH%20Conference%20FINAL%20DRAFT.pdf

[80] https://orpca.org/wp-content/uploads/2024/04/2023-Annual-Report-FINAL.pdf

Examples of State APMs that Include Incentive Payment Approaches			
State	**Incentive Approach Methodology**	**Quality Metrics**	**Outcomes**
	centered care that will result in a reduction in traditional, billable patient visits. The APM converted the clinic's current PPS rate into an equivalent PMPM rate using historical patient utilization and the medical-only cost base rate for the specific clinic.		A 2020 study in *Health Affairs* reported: • The payment reform was associated with a 42.4% relative reduction in price-weighted traditional primary care services, driven fully by decreased use of imaging services (radiographs, ultrasounds). • Other outcomes remained unaffected.[81] A companion study showed higher use of e-visits and telephone visits — services not billable under traditional Medicaid rules.[82]
Washington State[83]	Called APM4, the program ended on December 2022. HCA is currently evaluating the quality, cost, utilization and financial impacts of the program.[84] The basic construct of the Washington State FQHC APM4 was to calculate an individual per member, per year (PMPY) budget neutral amount for each FQHC and pay that amount in a PMPM amount. Washington Medicaid paid a PMPM rate in addition to the amounts the MCO paid that FQHC.	• Comprehensive Diabetes Care - Poor HbA1c Control (>9%). • Comprehensive Diabetes Care - Blood Pressure Control (<140/90). • Controlling High Blood Pressure (<140/90). • Antidepressant Medication Management - Effective Acute Phase Treatment. • Antidepressant Medication Management -- Effective Continuation Phase Treatment (6 Months). • Childhood Immunization Status - Combo 10. • Well-child visits in the 3rd, 4th, 5th and 6th years of life.	Results of a 2022 study of 2015--2020 data results: • Quality: Compared to non-participating FQHCs, patients assigned to APM4 FQHCs showed no statistical improvement on seven of nine quality measures in the original contract. There were statistically significant improvements in two diabetes outcomes measures (blood pressure and hemoglobin A1c control).

[81] https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.01656
[82] https://www.ohsu.edu/sites/default/files/2020-07/Policy%20Brief%20eCHANGE.pdf
[83] https://app.leg.wa.gov/WAC/default.aspx/default.aspx?cite=182-548-1400, https://www.hca.wa.gov/assets/billers-and-providers/FQHC-bg-20210701.pdf
[84] https://www.hca.wa.gov/assets/program/apm4-fact-sheet.pdf

Examples of State APMs that Include Incentive Payment Approaches			
State	**Incentive Approach Methodology**	**Quality Metrics**	**Outcomes**
			• Cost: There is evidence that FQHCs that did not participate in the APM4 program had higher costs per member month than did APM4 participants prior to implementation of the payment model, and this gap may have slightly widened following implementation. The total cost of care for members assigned to APM4 participants was $8 lower PMPM relative to non-participating FQHCs, though this finding had minimal statistical significance for such a large data set. The $8 PMPM in lower cost was largely canceled out by payments that exceeded the prior APM3 entitlement ($7.92 PMPM). • Utilization: APM4 participants and non-participants experienced similar decreases in the probability of an assigned member having an emergency department visit, a primary care visit, and in the total number of claims.[85]

[85] https://www.hca.wa.gov/assets/program/leg-report-APM4-evaluation-20230112.pdf

Examples of State APMs that Include Incentive Payment Approaches			
State	**Incentive Approach Methodology**	**Quality Metrics**	**Outcomes**
Washington D.C.[86]	Additional payment based on performance evaluated by metrics. A performance bonus funding pool is established each year. The final rule states that for the first Measurement Year (MY1), beginning on October 1, 2018, the amount of the performance bonus funding pool available for payment shall be the difference between all the District's FQHCs' uncapped administrative cost and the District's FQHCs' capped administrative cost reflected in 2013 audited cost reports. For MY2 and future years, the amount of the performance bonus funding pool shall be the amount available in the previous year pool, adjusted annually by the percentage increase in the Medicare Economic Index, established in accordance with Section 1842(i)(3) of the Social Security Act. FYs: 2019 - $3M 2020 - $3.045M 2021 - funding pool suspended State Plan indicates program will resume in 2026. [87]	FQHCs will be measured on seven performance measures, within three domains: • Patient-Centered Access • Clinical Process • Utilization.	Points for each performance measure are awarded in cases where an FQHC meets either the attainment or improvement benchmark based on the prior year's performance. FQHCs are assessed based on either the attainment of the goal or improvement to a defined threshold.

[86] https://www.medicaid.gov/medicaid/spa/downloads/DC-24-0014.pdf
[87] https://www.medicaid.gov/medicaid/spa/downloads/DC-24-0014.pdf

Nursing Facility

In September 2019, DSS initiated its nursing facility modernization project. One of the goals in modernizing nursing facility reimbursement was to establish a reimbursement framework to align with value-based payment in the future. Through an extensive stakeholder process, memorialized on the Department's website, DSS worked with various stakeholders over several years to design the acuity based reimbursement system.[88] Acuity reimbursement aligns Medicaid payment with a guiding principle to support resident care by:

- *Aligning payment with the anticipated resource need of each nursing facility based on the acuity of their specific residents,*
- *Providing incentives for nursing facilities to admit and provide care to persons in need of comparatively greater care,*
- *Implementing quarterly adjustments to reimbursement rates that account for changes in the acuity mix of each nursing facility's residents, and*
- *Encouraging nursing facility spending on direct care resources.*

Upon full implementation, the quality incentive payment will result in additional payments to certain providers. The program was introduced in SFY 2024 and initially consists of seven quality measures. There was no financial impact to providers in SFY 2024. The quality data used in the program is obtained from publicly available CMS quality and staffing hours data, with the exception of a CoreQ satisfaction survey. A CoreQ satisfaction survey is a set of standardized questions that measure the satisfaction of residents, patients, and families in assisted living communities and skilled nursing centers.[89] Underlying quality data has been updated quarterly and distributed to providers in SFY 2024 and will continue in SFY 2025. Provider workgroups assisted in determination of the quality measures selected. Additional information on the workgroup work is memorialized on the DSS webpage.[90]

- *DSS is in the process of preparing a report, mandated as a result of the 2023 legislative session, on the nursing facility quality metrics program, which is due to the joint standing committees of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies and human services no later than June 30, 2025. This report is to include information regarding individualized reports and the anticipated impact*

[88] https://portal.ct.gov/dss/health-and-home-care/medicaid-nursing-home-reimbursement/nursing-home-reimbursement-acuity-based-methodology

[89] DSS has contracted with UConn Center for Aging to conduct the CoreQ survey in each Connecticut nursing home. As of the date of this report, CoreQ survey work continues and surveys are not yet complete. Detail and results will be posted to the DSS webpage once survey work is finished.

[90] https://portal.ct.gov/dss/health-and-home-care/medicaid-nursing-home-reimbursement/nursing-home-reimbursement-acuity-based-methodology

on nursing facilities if the state were to implement a rate withhold on nursing facilities that fail to meet certain quality metrics.

- *A report published in 2022 by The Center for Health Policy Evaluation in Long-Term Care included a summary of recommendations for a successful value-based payment program.[91] Myers and Stauffer recommends that the Department consider the recommendations in the literature when making decisions as they make updates to their program in the future.*
- *Myers and Stauffer also examined the quality programs in the five comparison states. Four out of the five comparison states have quality incentive programs.*
- *Maine is in the process of implementing a nursing facility rate reform with a three-year phase-in period scheduled to begin July 1, 2024. A value-based payment program is a component of the Maine nursing facility rate reform. A portion of the rate will be tied to achieving quality thresholds and there will be an opportunity to earn more for exceptional quality. MaineCare has included measures addressing staffing levels/stability, person-reported outcomes, clinical outcomes, and high MaineCare utilization. As this program is still under development, no further detailed information such as the number of measures being evaluated is available at this time.*
- *Information was not available describing how implementation of the quality programs in the other comparison states influenced quality in the nursing facilities.*

Table 51: Quality Program Comparison

Nursing Facility Quality Program Comparison				
State	**Program**	**Program Effective Date**	**Funding**	**Measures**
Connecticut[92]	Quality Metrics Program	July 1, 2023	Reporting only, no financial impact.	• 7 Quality Measures • Uses CoreQ
Massachusetts[93]	Medicaid Quality Incentive	October 1, 2020	State and Federal Funds; $95 Million in 2021	• 4 Quality Measures
Maine[94]	Value-Based Payment	Scheduled for July 1, 2024, but not implemented to date	Unknown	• Unknown

[91] The Center for Health Policy Evaluation in Long-Term Care. A Review of Nursing Home Medicaid Value-Based Payment Programs. Brown, MPH Erin; Domi, MPH, Marsida; Gifford, MD, MPH, David. February 23, 2022.

[92] Reimbursement Modernization Stakeholder Webinar April 14, 2022 https://portal.ct.gov/dss/health-and-home-care/medicaid-nursing-home-reimbursement/nursing-home-reimbursement-acuity-based-methodology

[93] Commonwealth of Massachusetts. 101 CMR 206.00: Standard Payments to Nursing Facilities. October 1, 2023.

[94] MaineCare Department of Health and Human Services. Nursing Facility Rate Reform Framework. Update February 22, 2024. https://www.maine.gov/dhhs/blog/maine-dhhs-proposes-framework-nursing-facility-rate-reform-2024-02-23

Nursing Facility Quality Program Comparison				
State	**Program**	**Program Effective Date**	**Funding**	**Measures**
New Jersey[95]	Quality Incentive Payment Program (QIPP)	July 1, 2019	State and Federal Funds supplemented with a Provider Tax; $20 million paid in 2022.	• 6 Quality Measures • Uses CoreQ
New York[96]	Nursing Facility Quality Initiative (NHQI)	Established in the 2010-2011 final State budget	Budget Neutral with positive and negative payment adjustments; $50 million paid in 2023. To fund the $50 million pool, every nursing facility's contribution is calculated as follows: (Calendar Year Promulgated Rate*MA Days/Statewide NH Total MA Revenue)*$50,000,000	• 15 Performance Measures • 2 Compliance Measures • 1 Efficiency Measure

[95] New Jersey Legislature. P.L.2019, CHAPTER 150. Approved June 30, 2019.
[96] New York State Department of Health. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/vbp_alignment_paper_final.pdf September 2015.

Appendix D:
HCBS Rate Study
Final Report
Phase 1 and Phase 2
December 31, 2024

MYERS AND STAUFFER LC
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Project Overview

The Connecticut Department of Social Services (DSS) contracted with Myers and Stauffer LLC to review the methodology for home and community-based services (HCBS) 1915(c) waiver program rates for DSS and the Department of Developmental Services (DDS). In a Centers for Medicare and Medicaid Services (CMS) Information Request for Additional Information, CMS noted that rate methodologies were outdated (2014 if not earlier) and required that DSS review and update methodologies for the waiver amendment approval. The objective was to develop a rate methodology with various rate components that can be modified to determine revised rates as those components change.

The HCBS rate study was done in two phases with Phase 1 covering DSS services for the services and waivers shown in *Tables 1* and *2*.

Table 1: HCBS Rate Study DSS Phase 1 Services

HCBS Rate Study DSS Phase 1 Services	
• ABI Group Day • Adult Day Health • Adult Family Living • Assisted Living • Bill Payer • Brief Episode Stabilization • Case Management • Chore Services • Cognitive Behavioral Programs • Community Living Support Services • Community Mentor • Community Support • Companion Services • Home-Delivered Meals • Homemaker Services	• Independent Living Skills Training • Interpreter • Job Coaching • Life Skills Coach • Mental Health Counseling • Nursing Supports • Peer Supports • Personal Care • Pre-Vocational Service • Recovery Assistant • Respite • Social Skills Group • Substance Abuse Programs • Supported Employment • Transitional Living Services

Table 2: HCBS Rate Study DSS Phase 1 Waivers

HCBS Rate Study DSS Phase 1 Waivers	
• Acquired Brain Injury 1 and 2 • CT Homecare Program for Elders • Katie Beckett	• Mental Health • Personal Care Assistance • Persons with Autism

Phase 2 of the HCBS rate study covered the DDS services and waivers shown in *Tables 3* and *4*. There were some overlapping services in both phases.

Table 3: Rate Study DDS Phase 2 Services

HCBS Rate Study DDS Phase 2 Services	
• Adult Day Health • Blended Supports • Cognitive Behavioral Programs • Community Companion Homes • Companion Services • Continuous Residential Support • Customized Employment • Day Supports • Employment Transition	• Health Care Coordination • Individual Home Supports • Parenting Supports • Peer Supports • Personal Care/Shared Living • Respite • Senior Supports • Supported Employment

Table 4: Rate Study DDS Phase 2 Waivers

HCBS Rate Study DDS Phase 2 Waivers	
• Comprehensive Supports • Employment and Day Supports	• Individual and Family Supports

Study Limitations

Due to the study's limitations, further analysis is needed before financial investments are made. The benchmark for comparison used in the report serves as a comparison point and does not represent recommended reimbursement rates. Before applying these comparisons for revising or "rebasing" rates, DSS should first select which benchmarks to use and how they should be applied to services that support person-centered care and access. The current rate system does not include timelines for rate adjustments, nor does it recognize increases or changes in the system, such as inflation, workforce changes, and updates to clinical best practices. This makes it difficult for providers and the Departments of Social Services and Developmental Services to track rates on an ongoing basis. Currently, rate changes have been mandated on an isolated case-by-case basis through legislation or funded by specific state budget appropriations. Thus, some areas of the program have received significantly more frequent or significant rate increases without any evidence-based assessment of sufficiency of rates by service. Moreover, the current system forces the Departments to focus their limited administrative resources in implementing isolated mandates and are not able to address program priorities, such as member experience, proactively and comprehensively.

Further, Myers and Stauffer received only 50 cost survey submissions out of approximately 520 HCBS providers. *Table 5* below shows the provider cost report submissions containing the specific service

counts and estimated percent of revenues covered by the submissions. Given the low response rate from providers, additional analysis is needed to determine where future investments should be made.

Table 5: Rate Study Survey Responses

Submissions by Service			
	Providers	**Submissions**	**Estimated Percent of Revenues Covered**
Adult Companion	49	2	3.07%
Adult Day Care	29	8	36.17%
Assisted Living	3	0	0.00%
Personal Care Attendant	227	11	4.39%
Case Management	5	1	21.68%
Chore	24	1	0.88%
Day Habilitation	6	2	74.41%
Home Delivered Meals	3	1	66.12%
Homemaker	117	7	10.11%
Personal Care Services	188	15	15.01%
PERS	8	1	0.45%
Residential Habilitation	6	2	48.74%
Respite	92	6	5.63%

From the cost data that was received by providers, Myers and Stauffer summarized and arrayed reported data in a variety of ways to best determine its use for the rate setting methodology. Costs were reviewed by component (a process described in more detail later in this document) with analysis focused on direct service worker wage by position and the grouping of costs across similar services where they align. The data analysis yielded significant volatility across providers and within service types for a variety of expenditure components. This volatility is not uncommon or unexpected and to smooth this volatility, Myers and Stauffer utilized measures of central tendency, such as medians and weighted averages, to establish service-specific costs and percentages for the rate setting methodology – this process is known as the *Rate Build-Up Methodology* and is a common, CMS-accepted HCBS rate setting methodology. The Rate Build-Up Methodology section of the report discusses the process in more detail and is used as a benchmark for illustrative benchmark comparison only. Given the limitations, further analysis is needed before investments are made.

Stakeholder Engagement

Stakeholder engagement activities related to this HCBS rate study were structured to capture feedback from both internal (DSS) and external (service provider) parties. Internal stakeholder activities began in April 2020 with an initial focus on understanding service and service delivery nuances of the DSS HCBS 1915(c) waivers, historical rate or service access issues, or other challenges noted by DSS. Myers and Stauffer participated in a series of meetings with DSS program and reimbursement subject matter experts and conducted weekly touchpoints throughout the rate review process to ensure transparency and alignment.

In addition to maintaining regular communication with DSS staff, a high level of importance was placed on external stakeholder engagement with the service provider community. Engagement with the service provider community is essential in understanding the challenges currently being faced in service delivery. Myers and Stauffer conducted external stakeholder meetings on May 26, 2020, June 23, 2020, July 7, 2020, and April 7, 2021, that included the following objectives:

- *Provide an overview of the rate development timeline to stakeholders.*
- *Discuss the development and design of the cost survey to capture service-specific provider cost experience.*
- *Present and discuss proposed rate methodology and service level assumptions based on cost surveys, service requirements, and stakeholder feedback.*

Throughout the course of this rate study, Myers and Stauffer worked with stakeholders from both DSS and DDS to analyze the service rates, service descriptions, reported provider costs, and utilization of services. Additionally, DSS and DDS were tasked with providing recommendations on the services and programs evaluated in the rate study, which include using the information produced through the rate study and other available information to identify areas of focus.

DSS identified the following areas of focus:

- *Ensuring rates for Companion services are adequate to increase service access.*
- *Working with the providers of services through the Persons with Autism waiver to assist them with care plan access issues and other related concerns to ensure CMS requirements for member access are being met.*
- *Evaluating access to care on the Mental Health waiver for Mental Health Counseling services and making certain there are enough Counselors enrolled to provide services for individuals on the Mental Health waiver.*

- *Evaluating the quality of care provided by recovery assistants to individuals on the Mental Health waiver.*
- *Reviewing rate parity related to services administered though the State Plan compared to the waiver programs, and specifically, rate variances in services provided through the Persons with Autism waiver and the Personal Care Assistance waiver.*
- *Evaluating the ability to promote use of the supported employment services in an effort to improve outcomes for individuals.*

Cost Survey Overview

Cost Survey Design – Phase 1

Best practice in rate review procedures dictate that direct costs of provider service delivery need to be obtained. However, collecting cost-related data from HCBS providers can be time consuming and difficult. Many HCBS providers are unaccustomed to reporting costs in a structured format and few have accounting systems designed to easily segregate service line expenditures. As such, specifically designed cost collection tools, directed training efforts, and prompt filing support are necessary to collect aggregate and service-specific costs. The cost collection process for this initiative was conducted in a manner understandable to providers and reduced administrative burden where possible. Myers and Stauffer followed several key principles in designing the HCBS provider cost report, including those listed below.

- *A cost report must capture the minimum required information that can effectively communicate the provider's service delivery expenses.*
- *The organization and format of the cost survey (e.g., Excel-based versus web-based survey tools) must allow providers to accurately submit data using language that mirrors generally used accounting reports as closely as possible.*
- *Thoughtful consideration should be paid to the level of complexity and number of services included in cost collection efforts, as well as the availability of information from other data sources.*
- *Provide for default allocation of shared costs, such as administrative expenditures or program-related costs for similar services.*
- *Data must be readily available for extraction and use in rate review.*

Myers and Stauffer designed and refined the Connecticut HCBS cost survey for Phase 1 DSS services through several discussions with the state and provider community representatives. The cost survey was presented to providers on June 23, 2020, and July 7, 2020, to solicit feedback and prepare the provider community for the upcoming data request. Internal and external feedback was used to adjust certain cost survey elements, add, or modify questions, and to provide additional clarification or instruction where necessary. The final Phase 1 cost survey reporting instrument is available on the Myers and Stauffer Connecticut website and contains the following information:

- ***Instructions.*** *General instructions for filing and contact information for questions.*
- ***Provider Data.*** *General provider information, such as name, Medicaid number, address, etc.*
- ***Services.*** *Providers indicate the program services, by waiver, delivered by the organization.*

- ***Units & Revenues.*** *Providers enter billed units and related revenue.*
- ***Admin Staffing.*** *Reporting of administrative personnel wage, overtime, and bonus payments by position type. This section allows for identification of allowable versus non-allowable administrative staffing time and cost.*
- ***Direct and Program Staffing.*** *Reporting of program and direct service worker wage, overtime, bonus payments, annual turnover, and training hours by position type. This section allows for the allocation of time to services included in the rate study, as well as other services provided by the organization. Program staff support the provision of direct care, but generally do not provide it directly (direct care supervisors, etc.).*
- ***Expenses.*** *Collection of overall working trial balance expenses segregated into employee benefits, direct care, program, administrative, room and board, and non-reimbursable areas.*
- ***Allocation Basis.*** *Details allocation methods used to allocate program related expenses on the Expenses worksheet.*
- ***Benefits.*** *Collection of PTO days and paid benefit expenses.*
- ***Service-Specific Worksheets.*** *Collection of service-specific information, such as caseload and service design, staffing ratios, work week productivity, and transportation.*

Phase 1 cost survey collection and support activities were conducted in 2020 from late July through November. The Myers and Stauffer team is deeply appreciative of the provider community for engaging in the cost survey process during the expedited collection period.

Cost Survey Collection – Phase 1

With cost survey completion being a relatively new experience for the Connecticut DSS HCBS provider community, there was substantial effort dedicated to provider filing assistance. Myers and Stauffer conducted a live cost survey training on August 5, 2020, for the provider community. The cost survey training included a full walkthrough of the cost survey template. The Myers and Stauffer Connecticut website includes the recorded and posted training, along with a Word document containing frequently asked questions related to the cost survey. For questions and file submissions, the Myers and Stauffer team established a dedicated email address with staff dedicated to monitoring the account for quick response.

Provider submissions were open from July 27, 2020, through October 2, 2020; however, the state and Myers and Stauffer did allow for some flexibility and accepted submissions through November 17, 2020.

Cost Survey Review – Phase 1

Once the Phase 1 completed surveys were received from providers, Myers and Stauffer performed basic checks for completeness and formulaic errors and removed any account descriptions not allowed per CMS Publications 15-1 and 15-2. This includes items such as penalties and promotional marketing. Data reviewers contacted providers for clarification and potential revisions when items were incomplete or appeared incorrect. No review or attest procedures were performed on the cost survey submissions, and as such, no opinion is expressed relating to the completeness or accuracy of the data received and ultimately utilized for rate setting purposes. After cost survey submissions were remedied for obvious issues, the cost survey information was extracted and compiled into an analytical database.

Cost Report Review – Phase 2

Providers of DDS services submit cost reports on an annual basis. Submitted cost report information for fiscal years 2022 and 2023 was extracted and compiled into a database for analysis.

Cost Report Analysis – Phases 1 and 2

Myers and Stauffer summarized and arrayed reported data in a variety of ways to best determine its use for the rate setting methodology. Costs were reviewed by component with analysis focused on direct service worker wage by position and the grouping of costs across similar services where they align. The data analysis yielded significant volatility across providers and within service types for a variety of expenditure components. This volatility is not uncommon or unexpected, particularly for states that do not have an existing and well-defined provider cost collection process. To smooth this volatility, Myers and Stauffer utilized measures of central tendency, such as medians and weighted averages, to establish service-specific costs and percentages for the rate setting methodology. The *Rate Build-Up Methodology* section of this report discusses the use of the cost data in more detail.

Rate Build-Up Methodology

Overview

The rate build-up methodology is a common, CMS-accepted HCBS rate setting methodology. This rate setting approach involves building a rate by estimating and adding together each component of cost necessary to deliver a service. Provider cost report data, Bureau of Labor Statistics (BLS) wage categories, and/or other national benchmark information are utilized in determining the cost components, which are then summed to create the total rate. These rates are commonly expressed in 15-minute, hourly, or daily increments. HCBS services are not able to be compared to other states or Medicare due to the differences in state programs. Therefore, the rate build-up method is used to create a point of comparison and does not reflect recommended reimbursement rates. Further analysis into program policies and procedures to align with best practices, such as assessment-supported person-centered planning, is needed before rate adjustments should be made.

The rate build-up methodology is traditionally comprised of two major cost areas: Total Employee Cost and Total Operations Cost. ***Error! Reference source not found.****6* describes the components that make up each of these two cost areas in more detail.

Table 6: Rate Structure Example

Rate Structure Example		
Total Employee Cost		
(A) Hourly Wage		$19.43
(B) Employee-Related Expenses	25.05%	$4.87
(C) Productivity Factor	1.24588	$5.97
Direct Service Provider Wage and Benefits		$30.27
Total Operations Cost		
(D) Program-Related Expenses	20.40%	$3.96
(E) General/Administrative	11.25%	$4.34
Total Cost per Hour		$38.57

Total Cost per Hour / 4 = 15-minute Billing Unit

There are elements of the rate build-up equation unique to each service type, while others calculate as a static and uniform percentage across service types. In the rate model example above, cost component (E) calculates as a static percentage applied across services and waivers. Conversely, components (A), (B), (C), and (D) are independently derived from cost survey data and BLS wage data for each service. It should be noted that, as required by CMS, room and board costs are not included in service rate development.

Component Descriptions

The components of the rate structure example represent the costs of delivering Medicaid services. The two broad categories of costs included in this model are employee-related costs and operations-related costs. The total employee cost in the model is represented by components (A), (B), and (C). Employee-related costs include the wages paid to the person performing the service on behalf of the agency, the expenses the agency incurs in hiring and maintaining employees (payroll taxes, benefits, etc.), and a multiplier which increases employee costs to account for typical productivity (i.e., billable, and non-billable time). The total operations cost in the model is represented by components (D) and (E). Operations cost include indirect program-related expenses and general expenses for operating the business. The sections below describe each of these components in greater detail.

Component A – Hourly Wage

Wages are the amount of money an employee earned and paid to the employee. This model begins with an hourly wage expectation, with wages adjusted to incorporate an inflation factor applied through December 2024. The selected inflationary index is the Employment Cost Index for Private Wages and Salaries (+8.67% index factor) published by the Congressional Budget Office in *An Update to the Economic Outlook: 2023 to 2025* on July 26, 2023. The index factor has been applied uniformly to all hourly rate expectations for Phases 1 and 2 of the rate study, with the 8.67% inflation factor calculated as the inflationary change from Quarter 1 2023 through Quarter 4 2024.

In selecting an inflationary index, Myers and Stauffer identified an index relevant and applicable to the cost data it is used to adjust. The primary cost driver of HCBS rates is the direct service worker wage. The Private Wages and Salaries index is closely aligned with the primary direct service worker for the majority of the HCBS services under review.

For the wage component, Myers and Stauffer reviewed cost survey data for direct service wages and compared to BLS data for each service. In most cases, either sufficient information did not exist to determine positional wage, or the values submitted through the cost surveys were below expected wage targets. Wages from the BLS occupational wage database for Connecticut were utilized in place of submitted wage data for Phases 1 and 2 of the rate study to price services competitively. BLS occupational wage data establishes a taxonomy of job classifications by assigning a Standard Occupational Classification (SOC) code to each unique job position. Each service-specific calculation includes applicable SOC codes and related descriptions.

Myers and Stauffer reviewed the BLS occupational wage database for geographic wage differentials, specifically BLS codes 31-1120 ‘Home Health and Personal Care Aides’, 29-1141 “Registered Nurses”, and 29-2061 “Licensed Practical and Vocational Nurses." These positions had been mentioned by stakeholders to DSS and DDS as issues in certain areas of the state. Per BLS data, Connecticut has statewide information plus metropolitan area codes 71950 Bridgeport-Stamford-Norwalk, CT; 72850

Danbury, CT; 73450 Hartford-West Hartford-East Hartford, CT; 75700 New Haven, CT; 76450 Norwich-New London-Westerly, CT-RI; 78700 Waterbury, CT; and 0900001 Connecticut Nonmetropolitan Area. Myers and Stauffer, DSS, and DDS discussed the limited variation in the wage data based on geographic differentials and determined the statewide median is the recommended option.

The wage component will vary based on the level of direct service worker necessary to directly deliver the waiver service.

Component B – Employee-Related Expenses

Employee-related expenses, or component (B) in the example, is calculated as a percentage of the wage component (A). Employee-related expenses are employer-incurred costs related to payroll taxes, workers' compensation, health insurance, and other employee benefits associated with direct care staff wages. Myers and Stauffer recommend using 17.98% (part-time/hourly direct staff) and 26.51% (full-time/exempt direct staff) of the wage components.

The recommended percentages are calculated from BLS employment benefit data that includes costs related to legally required benefits such as Social Security (refers to the Old Age, Survivors, and Disability Insurance program), Medicare, federal and state unemployment insurance, workers' compensation, insurance, and retirement and savings. The included payroll tax percentages came from the Internal Revenue Service. The lower percentage for services with significant part-time/hourly direct staff includes reduced percentages for health insurance and retirement as cost survey information showed many organizations did not offer those benefits to part-time/hourly direct staff, or they were not utilizing those benefits.

The employee-related expense component was applied across all service rate models and was utilized to adjust the hourly wage value calculated in component (A). The rate value of component (B) is established by multiplying the calculated component (B) percentage by the component (A) hourly wage value.

While benefit and benefit uptake may vary by agency or service, benefits are an important part of staff retention and well-being. With benefit reporting showing wide ranges across providers, an expectation of benefits was applied to all services to ensure consistency in payment calculation.

Component C – Productivity Multiplier

In the case of Medicaid services, the productivity multiplier increases employee costs by considering the supporting activities which are critical to service delivery but are not directly reimbursable (i.e., non-billable time) per Medicaid service definitions. As such, these non-billable activities are "loaded" into the reimbursement rate to ensure providers receive sufficient reimbursement for the full cost of service provision.

Productivity multiplier calculations are based on several factors: billable time, PTO (vacation, sick, and holiday), non-productive hours, and training hours, among others. In this model, PTO is included at 10 days per year for services with significant part-time/hourly direct staff and 25 days per year for services with significant full-time/exempt direct staff. The standards were derived from the sum of the medians for each category (vacation, sick, and holiday) and staff level across all submitted Phase 1 cost surveys. Billable time, non-productive hours, and training hours vary for each service based on the specific needs and expectations of delivering those services, as well as data obtained from the submitted Phase 1 cost surveys.

The productivity multiplier component was applied as a unique value to each service rate calculation. The rate value of this component is calculated by taking the sum of the inflated hourly wage (A) plus the employee-related expense value (B), multiplied by 1, minus the productivity factor (C).

Component D – Program-Related Expenses

The program component of the rate build includes wages, benefits, and expenses for program-related costs, and any expenses for program requirements based on regulations. The expenses reported in this category indirectly relate to the participant's care but are still necessary for proper and adequate service provision. Examples include wages and expenses related to non-direct care program employees who complete member assessments, person-centered care plans, provider status reviews, training and oversight, supervision, and quality assurance. Program-related expenses are considered service-specific. The rate model relies on a median or weighted average program expense, depending on the service, based on data from the submitted cost surveys for Phases 1 and 2, with some similar services combined for consistency purposes.

Segregating program costs can be difficult for providers with more than one service line. As such, the cost survey allowed providers to allocate expenditures if direct assignment was not possible. The default allocation base for program costs is based on the percentage of time spent on each service (if completed by the provider), or by percentage of total direct care employee wage/contract expense for each service, should time spent not be completed.

The program-related expenses component of the rate build was applied as a unique percentage value to each service rate model. The rate value for program cost calculates as a percentage of component (D), multiplied by the inflated hourly wage of component (A).

Component E – General/Administrative

The general/administrative component of the rate model represents the general expenses related to operating the business, but not related to direct hands-on service provision. The cost in this model is represented as a general/administrative expense over total allowable expenses for the organization. It includes total allowable administrative wages, salaries, benefits, and operating expenses. Large

organizations were instructed to put centralized, shared services costs into the general/administrative category, which captures the share of expenses that support the waiver programs among other programs operated by those agencies. Across all cost survey submissions, the weighted average general/administrative component percentage was 9.15%. The 9.15% was determined as the proportion of allowable administrative expenditures relative to total cost.

The general/administrative component of the rate build was applied uniformly across the service rate models. The rate value for general/administrative expenditures calculates as a percentage of the total cost per hour determined by summing the Total Employee Cost and the Program-Related Expenses (D), then dividing by 1, minus the general/administrative percentage (E). Then the rate value for general/administrative is the total cost per hour, minus the sum of the Total Employee Cost and Program-Related Expenses (D).

Fiscal Impact

HCBS Rate Study Phase 1 Fiscal Impact

The HCBS rate study Phase 1 fiscal impact was developed using claims and cost information from fiscal year 2023 and compared to the *Rate Build-Up Methodology* described above. *Table 7* shows the fiscal impact model if all Phase 1 rates were compared to the current baseline payments to the rate build-up methodology. As previously mentioned, limitations in the study require additional analysis before recommendations for investments can be made.

1. Rates and rate methodology have not been updated in many years and it is not always clear how previous rates were calculated.
2. The current rates and methodology take into account the most recent minimum wage changes for Connecticut.
3. The below table incorporates the current delivery model for certain services which accounts for much of the increases.
    a. The proposed methodology for Personal Care services includes models for one and two live-in caregivers. The previous rates did not account for different models and associated differences in overtime.
    b. The proposed rate methodology for tiered case management aligns rates based on acuity and service hours.
    c. The proposed methodology for the Adult Day Health medical daily rate includes eight hours of nursing which accounts for much of the increase.
4. Seven service types comprise 93% of the difference between current baseline and the rate build methodology, resulting in $218,409,576 impact as shown in the table below.

Table 7: HCBS Rate Study Phase 1 Fiscal Impact by Service Type

	Baseline	Rate Build- Up Method	Difference
Total Modeled Payments	706,840,992	925,250,568	218,409,576
Categories expanded below:	**663,980,160**	**866,508,964**	**202,528,804**
Personal Care	396,025,280	517,400,275	121,374,995
Tiered Case Management	31,489,039	57,616,440	26,127,401
Companion Services	44,812,419	61,067,904	16,255,485
Adult Family Living	125,969,407	138,828,601	13,132,194
Independent Living Skills Training	36,764,180	47,079,310	10,315,130
Adult Day Health	12,577,169	20,873,300	8,296,132
Recovery Assistant	16,615,666	23,643,133	7,027,467

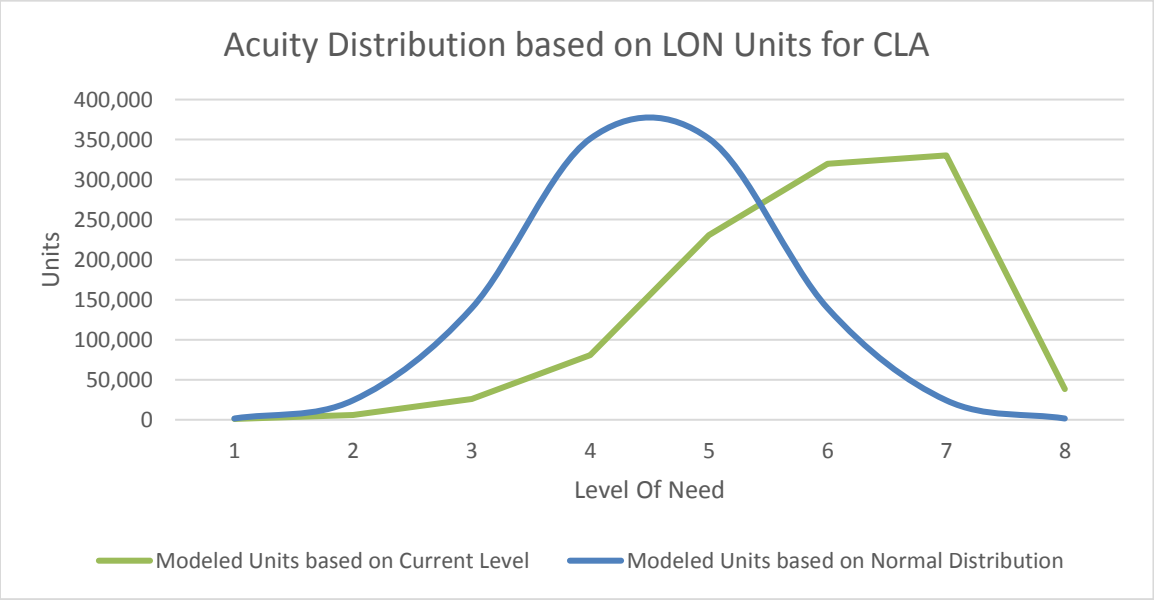
Other Categories	42,860,833	58,741,604	15,880,771
Total	**706,840,992**	**925,250,568**	**218,409,576**

HCBS Rate Study Phase 2 Fiscal Impact

The HCBS rate study Phase 2 fiscal impact has two parts as DDS services are claimed in a Certified Public Expenditure (CPE) arrangement between DDS and DSS. The first fiscal impact was developed using DDS claims and cost data paid to providers from fiscal year 2023. The second fiscal impact was developed using DSS waiver claims and cost information from fiscal year 2023.

During the study, it was noted that the utilization for DDS services has shifted to a higher acuity level. Generally, acuity is presented in a normal distribution or curve. While the current utilization is presented in a typical curve it has shifted to a higher acuity at the midpoint. For illustration, Figure 1 shows the distribution of units for Community Living Arrangements (CLA) utilizing the current Level of Need and compared to a normal distribution expected in such programs. This type of distribution of acuity seen throughout all the residential services included in the study, are likely one of the drivers toward higher expenditures.

Figure 1: Acuity Distribution in Community Living Arrangements (CLA)



Utilization data has a direct impact on the fiscal impact utilizing the updated rate methodology and there are any number of reasons that can result in a shift in acuity, including system changes that occur as a result of outdated rates, lack of a consistent and standardized functional assessment, availability of community integration opportunities, and demographic changes in the population both at the participant level and in the workforce. To illustrate the impact of utilization, the fiscal impact is shown

utilizing two models. Model 1 provides a fiscal impact of the rate build-up methodology changes with the current utilization. Model 2 provides the same rate methodology using a normal distribution of acuity.

Table 8: HCBS Rate Study DDS Fiscal Impact by Service Type

HCBS Rate Study DDS Fiscal Impact by Service Type				
	Baseline Model	**Model 1**	**Model 2**	**% of Fiscal Impact**
Total Modeled Payments	842,314,887	1,023,364,133	846,197,243	
Categories expanded below:	**835,674,264**	**1,014,160,549**	**826,282,752**	**96%**
Community Living Arrangement	425,016,956	520,776,149	369,927,611	53%
Individualized Home Supports	43,216,742	70,139,979	70,139,979	15%
Continuous Residential Supports	119,281,896	141,764,110	115,445,758	12%
Day Support Options	180,537,218	201,678,766	201,678,766	12%
Supported Employment	52,357,042	59,887,054	59,887,054	4%
Other Categories	6,640,623	9,203,584	9,203,584	4%
Total	**842,314,887**	**1,023,364,133**	**846,197,243**	**100%**

As illustrated in *Table 8*, the fiscal impact of Model 1 and Model 2 vary significantly. Model 1 results in an increase in expenditures of $181,049,246 whereas Model 2 results in an increase of $3,882,356. Further investigation into acuity trends and program policy is needed before implementing changes that could significantly impact program outcomes. Similar to Table 8, *Table 9* shows the difference between the two acuity models if they were applied to DSS services. Model 1 (current utilization patterns) results in an increase of $120,528,012 whereas Model 2 (utilization along the normal distribution) results in a decrease of $30,671,877. These modeled numbers should not be considered the recommended rate adjustment, but rather an illustration of the impact of program utilization shifts even within the same rate methodology.

Table 9: HCBS Rate Study DSS Fiscal Impact by Service Type

HCBS Rate Study DSS Waiver Fiscal Impact by Service Type				
	Baseline Model	**Model 1**	**Model 2**	**% of Fiscal Impact**
Total Modeled Payments	921,205,118	1,041,733,130	890,533,241	
Categories expanded below:	**901,571,721**	**1,019,357,169**	**890,532,241**	**98%**
Community Living Arrangement	423,256,657	500,004,263	371,466,118	64%
Individual Home Supports	77,901,040	106,015,859	106,015,859	23%
Continuous Residential Supports	121,153,711	136,323,874	113,662,130	13%
Day Support Options	210,993,609	220,199,036	220,199,036	8%

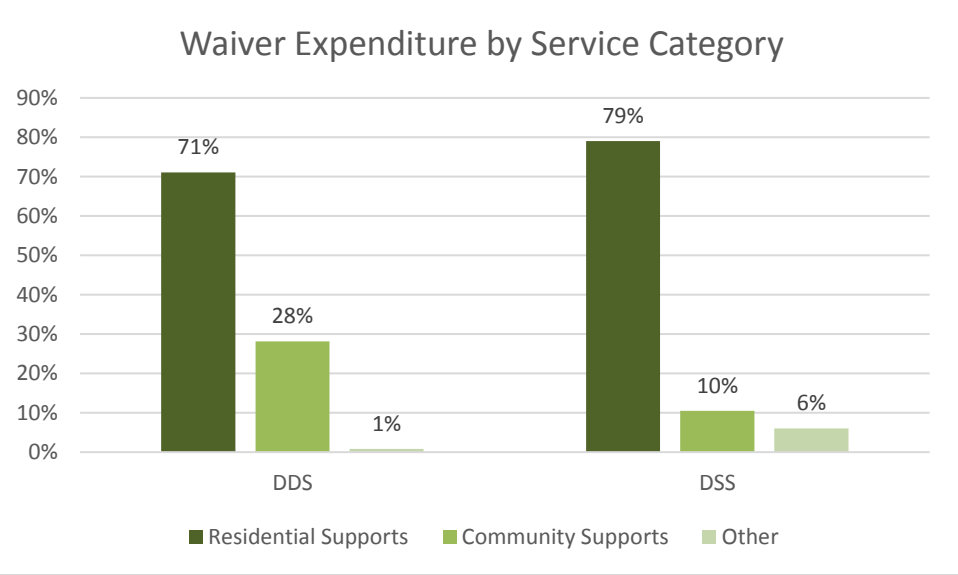
Supported Employment	68,266,704	56,814,137	56,814,137	(10%)
Other Categories	19,633,397	22,374,961	22,374,961	2%
Total	**921,205,118**	**1,041,733,130**	**890,533,241**	**100%**

Findings and Recommendations

Myers and Stauffer noted several findings and recommendations for consideration.

Finding 1: Average waiver costs are higher in Connecticut than in neighboring states and service utilization occurs predominantly in residential supports. In both waiver systems (those operated by DSS and DDS), expenditures associated with residential supports comprise more than 70% of total expenditures.[1] DDS system waiver expenditures in services designed to support community integration comprised less than one-third (28%) of the expenditures in these two waiver programs. While not unusual in waivers serving older members, waivers serving adults with physical and/or intellectual or developmental disabilities generally show a greater investment in community integration supports. *Figure2* below shows the breakdown of residential and community integration supports in each of the two waiver systems.

Figure 2: Waiver Expenditure by Service Category

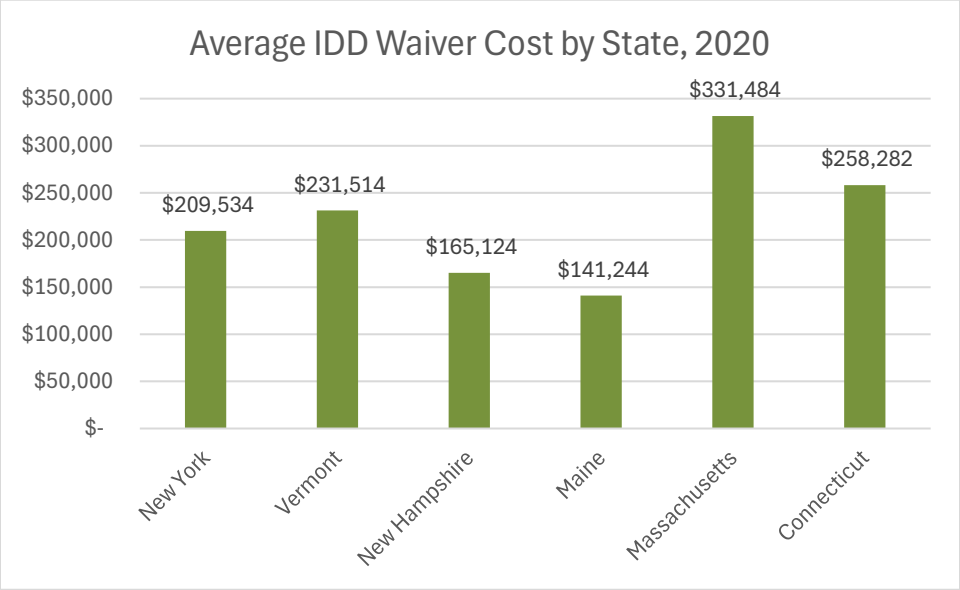


As discussed earlier in the report, the acuity levels of the waivers are distributed into higher levels of need than would normally be expected. This type of distribution of acuity seen throughout all the residential services included in the study, are likely one of the drivers toward higher expenditures. Further, waiver expenditures overall in Connecticut are higher than both the national average and the average of neighboring states' waiver expenditures. The University of Minnesota Residential

[1] Based on expenditure data collected and modeled during this rate study.

Information Systems Project (RISP) has compiled waiver costs for all states for waivers supporting individuals with intellectual and developmental disabilities (IDD).[2] The RISP study collected data for 30 years and while it concluded four years ago, using the final report and comparing Connecticut to neighboring states demonstrated that average per person costs were higher in Connecticut than in all but one neighboring state (Massachusetts). The 2020 RISP profile listed the average IDD waiver cost in northeastern states in 2020 at $215,780; for that same period Connecticut's average cost was $252,282. *Figure 3* provides a breakdown of average cost by neighboring state as reported in the RISP database.

Figure 3: Average IDD Waiver Cost by State[3]



Recommendation #1: DSS should examine the current HCBS service array, including the utilization of services and service descriptions, to determine if the policies that drive utilization in the waiver programs reflect the program goals, including providing for greater opportunity for community integration.

Recommendation #2: DSS should identify the population-based goals for each waiver and identify procedures and administrative models to support these goals.

Finding 2: Waiver eligibility and service planning do not currently employ a standardized, evidence-based assessment tool to aid in person-centered planning. A best practice in waiver management is the use of standardized assessments that are appropriately validated against the population of participating

[2] https://risp.umn.edu/about/overview
[3] https://risp.umn.edu/products/state-profiles

members. Standardized assessments are designed to measure functional level, identify strengths and areas of needed support, and establish the availability of natural supports. All these elements of assessment can provide critical information for identifying needs for supports and establishing thresholds to trigger tiered rates based on acuity or need. Accordingly, the HCBS quality measures recommended by CMS examine the use of functional assessments in the delivery of HCBS as a core indicator of quality care.[4]

Recommendation #3: DSS should examine the current process for assessing waiver members and consider adoption of standardized and validated tools that could provide a comprehensive assessment of functional needs, natural supports, and level of acuity.

DSS should also examine the program policies and procedures to align them with best practices such as assessment-supported person-centered planning. These actions may also help Connecticut to comply with the HCBS quality measures and provide for greater quality monitoring.

[4] https://www.medicaid.gov/federal-policy-guidance/downloads/smd22003.pdf

Future Considerations

The services provided through the waiver programs in Connecticut serve an important role in supporting and providing individuals with resources to better their quality of life. In addition to the recommendations included above, it is important to note that the work of improving the quality and providing continued access to services is an ongoing and evolving process.

Some of the additional considerations DDS is planning for in the near future include evaluating the need for a tiered case management system, which would also provide better tools for accountability and the potential restructuring of personal care service delivery in order to better meet individuals' needs. In addition, DSS is evaluating the impact of the CMS Access Rule and impacts related to collecting information from the personal care, homemaker, and home health services providers in meeting the requirements that 80% of all Medicaid payments benefit the direct support provider. Information will also be collected and reported for the services defined as habilitative services, although the 80% threshold for payments to direct support providers does not yet need to be met.

CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

Comparison of Connecticut Fee Schedule Methodologies to Other States' and Medicare's Methodologies

Appendix A

September 20, 2024

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Table of Contents

Introduction

Public Act 23-186, *An Act Concerning Nonprofit Provider Retention of Contract Savings, Community Health Worker Medicaid Reimbursement and Studies of Medicaid Rates of Reimbursement, Nursing Home Transportation and Nursing Home Waiting Lists*, requires the Commissioner of Social Services to conduct a two-part study examining Medicaid reimbursement. The Connecticut Department of Social Services (DSS) engaged Myers and Stauffer to conduct this study by evaluating Connecticut Medicaid's rates and rate setting methodologies for provider reimbursement and developing a road map for DSS to rationalize payment rates, payment methods, and methodological inputs and assumptions across the spectrum of services.

Phase 1 was completed in February 2024, and described the review of methodologies and rates for physician specialists, dentists, and behavioral health providers.

Table 1. Phase 1 Services

Phase 1 Services and Fee Schedules
Providers/Services
• Autism Spectrum Disorder (ASD) • Behavioral Health Clinician • Clinic Medical – select services • Clinic Rehabilitation – select services • Psychologist
• Dental Adult • Dental Pediatric
• Physician Office and Outpatient Services (excludes physician-administered drugs) • HUSKY Health Primary Care • Physician Anesthesia • Physician Radiology • Physician Surgical

Phase 2 review includes the following services.

Table 2. Phase 2 Services

Phase 2 Services and Fee Schedules		
Providers/Services		
Acupuncture	DME	MEDS-Misc
Ambulatory Surgical Services	FQHC	Naturopath
Audiology and Speech	Hearing Aid/Eye	Nursing Facility
Chemical Maintenance	Home Health	Optician/Eyeglasses
Chiropractor	Hospice	Physical and Occupational Therapy
Chronic Disease Hospital	Hospital Outpatient/Inpatient	Prosthetic/Orthotic
Clinic and Outpatient Hospital Behavioral Health	ICF (Private)	PRTF (Private)
Clinic - Family Planning	Independent Radiology	Transportation Air Ambulance
Clinic-Medical	Laboratory	Transportation Basic/Advanced
Clinic-Rehab	Medical Surgical Supplies	Transportation Critical Helicopter
Dialysis	MEDS-Enteral/Parenteral	

For each of the service categories, the rate methodology used by Medicare for those services covered by Medicare, and the methodologies used by states selected for comparison in this study were identified. Myers and Stauffer relied on publicly available sources of information, such as state regulations, publicly posted notices, and Medicaid state plan amendments. For Phase 1 methodologies and rates, information relied on was current as of June 2023. For Phase 2 methodologies and rates, information was current as of January 2024, unless otherwise noted.

The summary of the analyses related to both Phase 1 and Phase 2 is provided in Appendix A below.

Appendix A: Inventory of Phase 2 Methodologies

Acupuncture

Acupuncture						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[1]	Prospective.	See Physician and Outpatient.	CPT/HCPCS.	• Rates set effective October 2021. • Based on available applicable rates for the services that are within the scope of practice to be provided by licensed acupuncturists. • Acupuncture service billing codes were set at 57.5% of applicable 2021 Medicare rates. E/M codes were set at 100% of the Connecticut Medicaid physician office and outpatient fee schedule rates for the same codes, and the other codes not within either of those categories were set at 100% of the Medicaid physical therapy (PT)/occupational therapy (OT) fee schedule rates for the same codes.	N/A.	No set update schedule.

[1] https://www.ctdssmap.com/CTPortal/Provider/Provider-Fee-Schedule-Download; If provided in an outpatient setting or FQHC, payment methodology uses those fee schedules. Source https://www.huskyhealthct.org/providers/provider_postings/benefits_grids/Acupuncture_Provider_Benefit_Grid.pdf; https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/SPAs/SPA-21AG--Acupuncture-Chiro-Phys-FP-Clinic-Updates--Website-Notice--092321.pdf

Acupuncture						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Maine[2]	Not a covered benefit.					
Massachusetts, New Jersey, New York Oregon and Medicare	See Physician and Outpatient discussion.					

Ambulance

Ambulance						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[3]						
• **Air Ambulance**	Prospective.	Manually priced.	HCPCS.	Manually priced.	N/A	• Last updated 7/1/21. • No set update schedule.
• **Basic/ Advanced**	Prospective for all but A0170 (transport parking fees).	Fee schedule for all but transport parking fees, which are manually priced. Per service, mileage, wait time, staff	HCPCS.	• Fee schedule except for A0170, transport parking fees, manually priced. • State does not have documentation regarding how the methodology for these services was determined.	Modifier UA signifies a night charge; $19.50 is added to the fee schedule rate.	• Last updated 7/1/21. • No set update schedule.

[2] https://www.maine.gov/dhhs/oms/member-resources/coverage-benefits#:~:text=Some%20examples%20of%20services%20that%20are%20not%20covered%20include,Cosmetic%20surgery
[3] https://www.ctdssmap.com/CTPortal/Provider/Provider-Fee-Schedule-Download

Ambulance						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
		response person				
• **Critical Helicopter**	Prospective • Rotary wing (A0431) • Air mileage (A0436)	Fee Schedule. • Transport Mileage	HCPCS.	State does not have documentation regarding how the methodology for these services was determined.	N/A	• Last updated 7/1/21. • No set update schedule.
• **Non-Emergency Medical**[4]	Contract with MTM; MTM pays providers based on published fee schedule.	Competitive bid. Mileage, waiting time. Risk-based payment to MTM, PMPM amount for coordinating transportation.	HCPCS. Base rate plus mileage for livery taxi and for wheelchair.	MTM (previously Veyo) contracts with taxi and livery companies or independent drivers, disburses bus passes, and reimburses family and friends for mileage.	N/A	• Last updated 7/1/21. • No set update schedule.
Maine[5]	Prospective	Medicare fee schedule.	HCPCS.	100% of Medicare fee schedule rates for ground and air ambulance services.	N/A	Annual based on Medicare rates.
Massachusetts (Basic/ Advanced)[6]	Prospective	Fee schedule	HCPCS.	Methodology for determining fees is not published.	N/A	No information published about updates.

[4] https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Non-Emergency-Medical-Transportation/FAQ-for-NEMT-Document-Final-for-Posting-12-4-17.pdf?la=en; https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=pb23_61.pdf&URI=Bulletins/pb23_61.pdf

[5] https://www.maine.gov/sos/cec/rules/10/144/ch101/c3s005.docx

[6] https://www.mass.gov/doc/rates-for-ambulance-and-wheelchair-van-services-effective-september-29-2023-0/download

Ambulance						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
New Jersey	Prospective	Fee schedule	HCPCS.	Methodology for determining fees is not published.	N/A	No information published about updates.
New York[7]	Prospective	Fee schedule	HCPCS.	Methodology for determining fees is not published.	N/A	No information published about updates.
Oregon[8]	Prospective.	Fee schedule.	HCPCS.	Transportation broker approves and arranges for emergency transportation services. Base rate includes: • Any procedures or services provided, all medications, non-reusable supplies, or oxygen and all direct or indirect costs. "Indirect costs" include general operating costs, personnel costs, neonatal intensive care teams employed by the ambulance subcontractor, use of reusable equipment and any other miscellaneous medical items or special handling that may be required in the course of transport. • The first ten miles for ground ambulance transports • Mileage for air ambulance transports.	Supplemental payment programs are available to government and private ground emergency medical transportation providers, who are a government provider, pays the difference between costs and payments.	• Last update 5/12/23. • No information published about updates.

[7] https://www.emedny.org/ProviderManuals/Transportation/PDFS/Transportation_Manual_Policy_Section.pdf
[8] https://oregon.public.law/rules/oar_410-136-3020; https://oregon.public.law/rules/oar_410-136-3160; State Plan Attachment 4.19-B, page 1a.1

Ambulance						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				Additional payments may be made for: • A modified base rate may be paid for each additional client. • Payment for an extra attendant, if applicable • Compensation for service or care provided at the scene when the client did not require transport, if applicable. A CCO is responsible for reimbursement to providers of emergency ground or air ambulance for clients who are CCO enrollees. Rates are based on a combination of fixed rates and Medicare rates.		
Medicare[9]	Prospective.	Medicare Ambulance Fee Schedule.	HCPCS.; base payment plus mileage.	Fee schedule with two components • Base payment (RVU * ambulance conversion factor), adjusted for geographic factors (for the labor-related portion) • Mileage payment. The mileage rate is a standardized amount established by CMS and differs for ground and the two modes of air ambulance transport.	• Add-on payment policies tied to the mode of ambulance transportation and/or the geographic location of the point of pickup.	• Add-on adjustments in 2024 for ambulance transports that originate in urban-designated zip codes (2%); extra 50% mileage payment increase per mile on rural and super-rural transports. • Annual ambulance inflation factor is the

[9] https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_ambulance_final_sec.pdf

Ambulance						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				Seven levels of ground transport ambulance service, each assigned a different RVU representing the varying levels of service intensity: • BLS non-emergency. • BLS emergency. • ALS emergency. • ALS emergency (level 1). • ALS emergency (level 2). • Specialty care transport. • Paramedic ALS intercept. RVUs for six categories of ground ambulance transport are set relative to the value of the lowest intensity service, BLS non-emergency ground ambulance transport, which is assigned an RVU of 1.00. Air transports: • Fixed wing. • Rotary wing. • Service intensity varies based on whether the transport is emergency or non-emergency and the level of clinical staff required (basic life support or advanced life support The RVU for both of the air ambulance transport levels is set at 1.00, but much higher conversion	• The rural short mileage ground ambulance add-on payment policy increases the standard mileage rate by 50% for the first 17 miles of a ground transport if the pick-up zip code is rural. • The rural air transport add-on payment policy reimburses providers and suppliers 50% more than the urban air ambulance base payment and the mileage rate if the point-of-	CPI-U reduced by the 10-year moving average of multi-factor productivity. • Current RVU scale is the same as when implemented in 2002. The inflation factor is based on the consumer price index for all urban consumers (CPI–U) (U.S. city average) for the 12-month period ending with June of the previous year and is reduced by a productivity adjustment. • The current RVU scale remains the same as when it was implemented in 2002.

Ambulance						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				factors account for the higher costs associated with air transports. • Ground and air ambulance fee schedules are based on 100% of the national ambulance fee schedule. • Bundled rate includes items and services such as oxygen, drugs, extra attendants, and electro-cardiogram testing as medically necessary	pickup zip code is rural.	

Autism Spectrum Disorder Services

Autism Spectrum Disorder (ASD) Services						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut	Prospective fee schedule.[10]	CPT/ HCPCS.	Procedure Code (HCPCS/CPT); per quarter hour, hour, or per encounter.	Rates originally based on the cost of services when program was implemented in 2014. Code 90791 is not listed on the ASD fee schedule. 90791 is billed with modifier U5 when used for autism screening – psychiatric diagnostic evaluation.	Various rates are paid based on location, provider type, and/or patient age.	ASD fee schedule rates were updated and increased 4% as of 11/17/2021.[11] No regular update.

[10] https://www.ctinsider.com/news/article/autism-ct-rates-17796548.php
[11] https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/SPAs/SPA-21-AO---BH-Provider-Rate-Incr---Website-Notice---11-15-21.pdf

Autism Spectrum Disorder (ASD) Services						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Maine[12]	Prospective fee schedule.	CPT/HCPCS.	Procedure Code (HCPCS/CPT) per quarter hour or hour; behavioral health (BH) home paid on a PMPM basis.	Rates determined through the use of cost surveys supplemented with market data, and an independent cost build up methodology, using costs for direct care worker wages and benefits, , program support , and administration, and adjustments for productivity.	Adjustments for productivity built into the rate model; separate rates for BH homes (PMPM) and adult and children autism services.	1/1/2023; rates are scheduled for cost-of-living adjustment (COLA) increase 1/1/2024.[13]
Massachusetts[14]	Prospective fee schedule.	CPT/HCPCS.	Procedure Code (HCPCS/CPT); 15-minute rates.	Methodology for determining fees is not published.	Payment rate on H2014 varies based on bachelors (modifier HN) or master-level (modifier HO) clinician.[15]	Rates were effective 10/1/2022. No regular update.
New Jersey[16]	Prospective fee schedule.	CPT/HCPCS.	Per quarter hour or per encounter.	Rates determined based on comparison of rates from states with comparable Medicaid populations.	N/A	Updated 8/1/2023. No regular update.
New York[17]	Prospective applied behavior	CPT.	Per 15-minute increments.	Methodology for determining fees is not published.	N/A	Updated 4/1/2023.

[12] https://www.burnshealthpolicy.com/wp-content/uploads/2022/04/DHHS-BH-Rate-Study-Provider-Overview_2022-03-28.pdf; www.burnshealthpolicy.com/wp-content/uploads/2023/05/ME-Behavioral-Health-Final-Rate-Models_5-19-23-Final.pdf
[13] https://www.maine.gov/dhhs/oms/about-us/projects-initiatives/mainecare-rate-system-reform
[14] https://www.mass.gov/doc/rates-of-payment-for-applied-behavior-analysis-effective-october-1-2022-0/download
[15] https://www.mass.gov/doc/rates-for-certain-childrens-behavioral-health-services-effective-january-1-2023-0/download
[16] www.nj.gov/humanservices/dmahs/news/Provider_Newsletter_for_Applied_Behavior_Analysis_Therapy.pdf
[17] https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.emedny.org%2FProviderManuals%2FABA%2FPDFS%2FABA_Fee_Schedule.xls&wdOrigin=BROWSELINK

Autism Spectrum Disorder (ASD) Services						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
	analysis (ABA) fee schedule.					No regular update.
Oregon[18]	Prospective ABA, mental health (MH) outpatient services, and peer-delivered services fee schedules.	CPT/HCPCS.	Per 15 minutes; 30 minutes, and T1013 (translator services) is per service).	BH rates are reviewed on a case-by-case basis and often set or revised through federal or state legislative changes. Generally, rates as approved by legislators are 70% of Medicare rates.[19] Rates for new services are set after review of other state Medicaid fee schedules, Medicare rates, if applicable, and analysis with other partners such as OHA Actuarial Services and OHA's Health Policy and Analytics Division. [20]	Rates vary based on modifiers for location, or for individuals covered through waiver programs.	Updated 4/7/2023. No regular update.

[18] https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=246503
[19] https://www.oregon.gov/oha/HSD/OHP/Tools/BH-Fee-Schedule-Fact-Sheet.pdf
[20] OHA acknowledges that many CCOs strive to align their reimbursement structures with OHA's. However, CCOs are not required to implement the FFS Behavioral Health Fee Schedule as posted by OHA.

Behavioral Health Clinician Services

Behavioral Health Clinician Services						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut	Prospective fee schedule.	HCPCS.[21]	Procedure code (HCPCS/CPT) defined units per quarter hour, hour, encounter, or day.	Methodology determined using historical data that has not been updated.	N/A	None.
Maine	Prospective fee schedule.	HCPCS.	Procedure code (HCPCS/CPT) defined units per quarter hour, hour, encounter, or day.	• Based on a cost survey completed in October 2022. Cost survey covers community-based mental health and SUD services; new rates went into effect 1/1/2023.[22] • Cost survey uses a rate build up model which considers wages and benefits, travel costs, administration, and program support, and overhead. Costs are determined on the basis of 15 minutes. • Cost survey supplemented with data from the Bureau of Labor Statistics (BLS), the Internal Revenue Service, and special cost studies.	N/A	July 1st to be based on COLA percentage increase for the Northeast region.
Massachusetts	Prospective fee schedule.	HCPCS.	Procedure code (HCPCS/CPT) defined units per	• Cost reports from providers of similar BH services and budget data	N/A	N/A

[21] Behavioral health services are generally a mix of CPT and HCPCS in most states. This analysis incorporates the CPT codes in the physician table.
[22] https://www.burnshealthpolicy.com/wp-content/uploads/2022/04/DHHS-BH-Rate-Study-Provider-Overview_2022-03-28.pdf

Behavioral Health Clinician Services						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
			quarter hour, hour, encounter, or day.	from other purchasers of similar services. [23] • Maximum productive time was derived by assessing the time available for direct billable contacts by eligible direct care staff.		
New Jersey	Prospective fee schedule.	HCPCS.	Procedure code (HCPCS/CPT) defined units per quarter hour, hour, encounter, or day.	Rates derived from cost reports and special studies.[24]	N/A	N/A
New York	Prospective fee schedule.	State defined HCPCS outside of the capitation rate.	Procedure code (HCPCS/CPT) defined units per quarter hour, hour, encounter, or day.	Rates for the HCBS services (HARPS) are established using cost reports.[25]	Ongoing 10% HCBS enhancement. and 4% COLA.[26]	Annual.
Oregon	Prospective fee schedule.	HCPCS.	Procedure code (HCPCS/CPT) defined units per quarter hour, hour, encounter, or day.	Rates based on review of: • Other state Medicaid fee schedules. • Medicare rates, if applicable. • Cost studies. • Analysis with other partners such as OHA Actuarial Services and	N/A	N/A

[23] https://www.mass.gov/regulations/101-CMR-30600-rates-for-mental-health-services-provided-in-community-health-centers-and-mental-health-centers , https://www.mass.gov/regulations/101-CMR-30700-rates-for-psychiatric-day-treatment-center-services, https://www.mass.gov/regulations/101-CMR-30500-rates-for-behavioral-health-services-provided-in-community-behavioral-health-centers

[24] https://dmhas.dhs.state.nj.us/NJMHAPP/Content/Documents/FFS%20Program%20Provider%20Manual.pdf?AspxAutoDetectCookieSupport=1

[25] https://omh.ny.gov/omhweb/bho/harp-mainstream-billing-manual.pdf

[26] https://omh.ny.gov/omhweb/medicaid_reimbursement/

Behavioral Health Clinician Services						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				OHA's Health Policy and Analytics Division.[27]		

Chiropractor

Chiropractor						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[28]	See Physician and Outpatient discussion.					
New York[29]	Not a covered benefit (except co-pays and deductibles for Medicare beneficiaries).					
Maine, Massachusetts, New Jersey, Oregon, Medicare	See Physician and Outpatient discussion.					

[27] https://secure.sos.state.or.us/oard/view.action?ruleNumber=410-172-0640
[28] Documentation provided by DSS to Myers and Stauffer.
[29] https://www.emedny.org/ProviderManuals/Chiropractor/PDFS/Chiropractor_Policy.pdf

Clinic – Ambulatory Surgical Clinics

Clinic – Ambulatory Surgery Center						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[30]	Prospective.	Medicare fee schedule.	Bundled surgical service, per procedure (CPT); other fee schedules apply (lab, radiology, etc.).	Provider-specific fee schedule for most outpatient services; modeled after the Medicare methodology. 100% of the Medicare Ambulatory Surgical Center (ASC) fee schedule in place is 2007 (prior to implementation of OPPS). Some services paid on the basis of a flat fee schedule.	New codes priced based on similar procedure rates in 2008 Medicare fee schedule. There have been a few exceptions where codes were priced using a different methodology.	Codes added/removed yearly based on Medicare. Last update: January 2023.
Maine[31]	Prospective.	Fee schedule.	CPT/HCPCS.	100% of the lowest amount allowed by Medicare.	N/A	Annual.
Massachusetts[32]	Prospective.	Fee schedule.	CPT/HCPCS.	Methodology for determining fees is not published.	N/A	No information published about updates.
New Jersey[33]	Prospective.	Fee schedule.	CPT/HCPCS.	Methodology for determining fees is not published.	N/A	No information published about updates.[34]

[30] https://www.ctdssmap.com/CTPortal/Provider/Provider-Fee-Schedule-Download; ; Attachment 4.19-B to State Plan.
[31] https://www.maine.gov/sos/cec/rules/10/144/ch101/c2s004.docx
[32] https://www.mass.gov/doc/rates-for-freestanding-ambulatory-surgery-center-services-effective-february-2-2024-0/download; Massachusetts: https://www.mass.gov/regulations/130-CMR-423000-freestanding-ambulatory-surgery-center-services
[33] https://casetext.com/regulation/new-jersey-administrative-code/title-10-human-services/chapter-66-independent-clinic-services/subchapter-1-general-provisions/section-1066-15-basis-for-reimbursement
[34] On December 26, 2023, New Jersey submitted a public notice that the state plan would reflect that New Jersey Medicaid fee-for-service rates for State Plan services across all benefit categories were updated utilizing Medicare's annual update, with an effective date of January 1, 2024. Where more detailed information was available about the methodology applied, it is summarized in this appendix. The rates used for comparison purposes were those in effect on January 1, 2024. Source: https://www.nj.gov/humanservices/providers/grants/public/publicnoticefiles/Public%20Notice%20for%20Jan%202024%20rates%2011.20.23%20v4vam.pdf

Clinic – Ambulatory Surgery Center						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
New York[35]	Prospective.	Products of Ambulatory Surgery (PAS).	Surgical Procedure Group.	• Rate established for 45 PAS groups; statewide base rate is established for each of the payment groups defined in the PAS classification. • Each base price is adjusted by a wage equalization factor and a space occupancy factor to reflect regional differences in the price of labor and space. The wage equalization factor is applied to the operating room and pre-operative and post-operative nursing personnel salary components of each base price. • Cost ceilings are computed as 105 percent of the adjusted weighted average base year costs of the facilities in the cost center group.	N/A	Annual.
Oregon[36]	Prospective.	Medicare ASC fee schedule methodology.	CPT/HCPCS.	80 percent of the Medicare rate published January 1 each year.	N/A.	Annual.
Medicare[37]	Prospective.	Medicare ASC fee schedule.	CPT/HCPCS.	• Payment system that is primarily linked to the Hospital outpatient	CMS uses methods different from the	Both the relative weights and the

[35] https://regs.health.ny.gov/volume-2-title-10/914289984/subpart-86-4-free-standing-ambulatory-care-facilities

[36] Oregon State Plan, Transmittal 14-07, Attachment 4-19B, Page 1a.4

[3737] https://www.medpac.gov/wp-content/uploads/2024/03/Mar24_MedPAC_Report_To_Congress_SEC.pdf, https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_asc_final_sec.pdf;.

[89] https://www.maine.gov/sos/cec/rules/10/144/ch101/c2s004.docx

Clinic – Ambulatory Surgery Center						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				prospective payment system (OPPS). The ASC payment system is also partly linked to the PFS for payment of physician services. • Pays ASCs for a bundle of services and items through a system that is linked primarily to the outpatient prospective payment system (OPPS). • For services that were first covered under the ASC payment system in 2008 or later and for which volume is greater in freestanding physician offices than in ASCs, the ASC payment rate is set to the lesser of the standard ASC payment rate or the non-facility practice expense from the Medicare PFS. • For most covered procedures, payments for procedures are set using a set of relative weights, a conversion factor (CF) (or base payment amount), and adjustments for geographic differences in input prices. The CF used in the ASC payment system is less than that used in the OPPS.	one described above to set ASC payment rates for new, office-based procedures, separately payable radiology services, separately payable drugs, and device intensive procedures.	CF are updated annually. CMS updates the ASC relative weights based on changes to the OPPS relative weights and the physician fee schedule practice expense amounts. CMS updates the CF annually by the hospital market basket, minus an adjustment for multi-factor productivity growth.

Clinic – Ambulatory Surgery Center						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				• The ASC relative weight for a procedure, which indicates the procedure's resource intensity relative to other procedures, is based on its relative weight under the OPPS. The conversion factor transforms the relative weight for a service into a payment rate. Physician services are paid separately using the Medicare Physician Fee Schedule.		

Clinic – Chemical Maintenance

Clinic – Chemical Maintenance Services						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[38]	Prospective.	Provider-specific weekly rate that includes: • Intake evaluation. • Initial physical examination. • Medication administration,	Bundled rate; other fee schedules apply (lab, radiology, etc.).	Provider-specific reimbursement scheduled based on: • Provider cost reports. • Medicaid Management Information System claims data. • Subject matter expert regarding MH payment methods. • Providers' budget forecasts and financial information.	New providers are paid the weighted statewide rate.	Last update was in 2023 for one of the two codes.

[38] https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Health-and-Home-Care/Reimbursement/Chemical-Maintenance-Providers/CTSPA18_016_Chemical_Maintenance_Clinics_FINAL_APPROVED.pdf?la=en

Clinic – Chemical Maintenance Services						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
		including face-to-face medication administration or take-home medication. • On-site drug use screening and monitoring. • All routine individual, group, and family substance use disorder counseling services. Other services may be provided and paid for separately in accordance with the applicable reimbursement methodology for the service.		• Stakeholder input. At least one unit of the following categories of service per day for seven days must have been provided to bill for services: • In-person medication administration. • Take-home medication doses. • Any in-person clinical service provided at the clinic that meets the billing code clinical and minimum time definitions for individual, group, or family psychotherapy or any combination thereof. • A provider may bill multiple weekly rates during an in-person dispensing visit in order to account for the dispensed take-home doses up to the limitations in federal requirements for take-home doses, provided that the total number of doses billed is no greater than the total number of days allocated to each weekly rate. • For any week for which such a service is provided on fewer than		

Clinic – Chemical Maintenance Services						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				seven days, the Department shall prorate the rate to pay only for the number of days in the week during which such a service was provided.		
Medicare[39]	Prospective	• Medicare Part B: Covers methadone when it is obtained through an Opioid Treatment Program (OTP). • Medicare Part A: Covers methadone when a patient is an inpatient in a hospital setting. • Medicare Part D – the prescription drug program: May cover drugs like methadone,	Per day bundle	• Medicare OTP rates include weekly bundles that vary greatly based on the type of medication and method of administration. • Medicare also allows for intensive outpatient treatment and add-ons to the rate for acuity based on the needs of the individual receiving treatment, including take-home supplies of medication. • OTP rates vary in Medicare from a low of $259 to more than $5433 per instance based upon type of medication and administration.		Fee schedules are updated annually.

[39] https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se1604.pdf

Clinic – Chemical Maintenance Services						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
		buprenorphine, naloxone, and naltrexone.				

Clinic – Free Standing Dialysis

Clinic – Freestanding Dialysis						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[40],	Prospective.	Medicare fee schedule.	Per day, based on CPT/HCPCS procedure code; fee is all-inclusive, and includes routine laboratory, blood supplies, drugs, and surgical supplies.	• Fee for the physician's supervision of Continuous Ambulatory Peritoneal Dialysis is a monthly fee. • Dialysis services are reimbursed at approximately 100% of the 2007 Medicare physician fee schedule (participating, non-facility).	Reduced percentage for codes related to multiple procedures in one day.	• Rates for procedures initially set in 2008, with new or updated codes as recently as March 2020 (mostly for drugs). • No set update schedule.
Maine[41]	Prospective.	Medicare fee schedule.	CPT/HCPCS. Bundled per treatment: composite or	Current methodologies represent a mix of approaches. Methodology:	N/A	Maine scheduled the development of a new

[40] https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=ch7_clinic.pdf&URI=Manuals/ch7_clinic.pdf
[41] https://www.maine.gov/sos/cec/rules/10/144/ch101/c2s007.docx

Clinic – Freestanding Dialysis						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
			non-composite services.	• 90999 - National Medicare rate without adjustments for geography or other factors. • 90945 (Other CAPD), 90989, (training) 90993 (methodology not documented). • Other -100% of physician and professional fee schedule. • Other Medicaid fee schedules used to pay for non-composite or non-routine dialysis items or services.		methodology for 2024.
Massachusetts[42]	Prospective.	Medicare fee schedule.	CPT/HCPCS. All-inclusive rate covers services and supplies.	• All-inclusive rate for 90999 and G0491. • Add-on rates for training (90989, 90993) and J0604 (cincalcet). • Methodology for determining fees is not published.	N/A	• October 1, 2023. • No information published about future updates.
New Jersey[43]	Prospective.	Medicare fee schedule.	Bundled per treatment.	100% of the Medicare composite rate.	N/A	Annual.
New York[44]	Prospective.	Fee schedule, based on cost per patient grouping.	Per procedure; Includes are procedures, lab tests, and	• Uses the APG methodology, two APGs, one for hemodialysis and one for peritoneal dialysis. • One statewide rate.	N/A .	No information published about updates.

[42] https://www.mass.gov/regulations/130-CMR-412000-renal-dialysis-clinic-services
[43] New Jersey: State Plan Attachment 4.19-B, Page 2, TN 15-0001 MA.
[44] https://www.health.ny.gov/health_care/medicaid/rates/manual/docs/apg_provider_manual_december.pdf; The APG methodology is a classification system that pays the facility's cost of care. The basis of reimbursement is the categorization of the contact between the patient and health care provider. The contact could be categorized as either a procedure, a medical evaluation and management, or an ancillary service. For each interaction, a prospective weight and price is established that includes are routine services associated with the visit and/or procedure.

Clinic – Freestanding Dialysis						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
			physician administered drugs. Per Procedure			
Oregon[45]	Prospective.	Medicare fee schedule.	Per day, based on CPT/HCPCS. Fee is all-inclusive, and includes routine laboratory, blood supplies, drugs, and surgical supplies.	Pays 80% of the Medicare allowed amount published January 1 each year.	N/A	Annual.
Medicare[46]	Prospective.	Fee schedule, in consideration of treatment costs, including drugs, laboratory services, supplies, and capital-related costs.	CPT/HCPCS. Bundled per treatment.	• A patient-level and facility-level adjustment per treatment payment. • Single base rate for both adult and pediatric patients. • Rate is adjusted to reflect case mix. • Bundled payment includes drugs, laboratory services, supplies, and	Patient-level case mix, facility-level, training add-on, transitional drug add-on, transitional add-on payment adjustment for new and innovative	Annual, using end stage renal disease bundled market basket (base year 2016), minus a productivity adjustment, the most current wage index budget neutrality

[45] Oregon: State Plan Attachment 4.19-B Page 1a.4, TN 14-07
[46] https://www.cms.gov/medicare/payment/prospective-payment-systems/end-stage-renal-disease-esrd

Clinic – Freestanding Dialysis						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				capital-related costs related to furnishing dialysis services. Add-on for training for home and self-dialysis modalities, and additional payment for high-cost outliers if unusual variation in type or amount of medically necessary care.	equipment and supplies.	adjustment factor, and any other applicable budget neutrality adjustment factor.

Clinic – Family Planning Agency

Clinic – Family Planning Agency						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[47]	Prospective.	Medicare fee schedule.	CPT/HCPCS.	Fee Schedule is based on the 2007 Medicare fee schedule: • 80% of Medicare for the majority of professional services • 57.5% of Medicare for abortion and some surgical procedures • 95% of Medicare for lab services • Physician administered drugs are ether based on the 340B pricing supplied by PPSNE or 100% of the current year Jan Medicare Drug ASP Pricing file, or for manually priced drugs, uses the pharmacy lowest of methodology and select evaluation and management codes were updated to 90% of the CMAP Physician OBS rate type in July 2022.	N/A	July 2008, more recent updates mostly for injections. In July 2022, codes for evaluation and management services (99215, 99384 – 99386, 99394 – 99396) were increased to 90% of the CMAP Physician OBS rate type. No set update schedule.
Maine[48]	Prospective.	Medicare fee schedule.	CPT/HCPCS.	• Uses the same fee schedule as for other services, e.g., Physician, lab, outpatient hospital, etc. • Maine has developed an APM for family planning services. The APM benchmarks rates to 72.4-100%	N/A	No information published about updates.

[47] Information provided to Myers and Stauffer by DSS 1/19/2024; ctdssmap.com
[48] https://www.maine.gov/sos/cec/rules/10/144/ch101/c2s030.docx; https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/Maine%20FP%20APM_11.20_PRF%20Meeting%20Deck_FINAL%20v3_11.21.2023.pdf

Clinic – Family Planning Agency						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				of Medicare; provides fee schedule enhancements of up to 55% for achieving quality benchmarks. Practices would receive a PMPM payment to support care navigation (outreach and engagement, social needs screening, etc.). The APM was available for public comment in 11/23 but not yet implemented.		
Massachusetts, New Jersey, New York, Oregon	See Physician and Outpatient discussion.					
Medicare[49]	Prospective.	Fee schedule.	CPT/HCPCS.	Paid under existing fee schedules for Part A and Part B of Medicare.	N/A	Annual updates.

[49] https://www.kff.org/medicare/issue-brief/coverage-of-sexual-and-reproductive-health-services-in-medicare/

Clinic – Medical

Clinic – Medical						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[50]	Prospective.	Medicare fee schedule.	CPT/HCPCS defined units per quarter hour, hour, encounter, or day.	• Based on 80% of 2007 Medicare fee schedule (this fee schedule includes services reimbursed to school-based health centers that are licensed and enrolled as a freestanding clinic and **not** operated by a FQHC). • 100% of Medicare for COVID vaccines and vaccine administration. • 100% of the current year Jan Medicare Drug ASP pricing, for physician administered drugs, or for manually priced (MP) drugs, the lowest price in the pharmacy fee schedule.	N/A	No set update schedule.
Maine, Massachusetts, Oregon, Medicare	See Physician and Outpatient discussion.					
New York[51]	APG methodology.					

[50] https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=ch7_clinic.pdf&URI=Manuals/ch7_clinic.pdf; https://www.ctdssmap.com/CTPortal/Provider/Provider-Fee-Schedule-Download

[51] https://www.health.ny.gov/health_care/medicaid/rates/manual/docs/apg_provider_manual_december.pdf; The APG methodology is a classification system that pays the facility's cost of care. The basis of reimbursement is the categorization of the contact between the patient and health care provider. The contact could be categorized as either a procedure, a medical evaluation and management, or an ancillary service. For each interaction, a prospective weight and price is established that includes are routine services associated with the visit and/or procedure.

Clinic – Rehabilitation

Clinic – Rehabilitation						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[52]	Prospective.	Medicare fee schedule.	CPT/HCPCS defined units per quarter hour, hour, encounter, or day.	• Based on 95% of 2008 or 2013 Medicare fee schedule. • Payment to rehabilitation clinics started at 110% of the 2007 Medicare fee schedule in 2008. In 2015 (PB 2015-17), the rates were reduced to 95% of the 2008/2013 Medicare fee schedule as a budget option and those fees have been in place since then.	N/A	No set update schedule.
Maine[53]	Prospective.	Fee schedule.	CPT/HCPCS defined units per quarter hour, hour, encounter, or day.	• Methodology for determining fees is not published. • Also relies on rates from Physician, Speech and Hearing, Community Health Services, Individuals with ASD, etc., fee schedules.	N/A	No information published about updates.
Massachusetts[54]	Prospective.	Fee schedule.	CPT/HCPCS defined units per quarter hour, hour,	• Uses BH, CMHC, Physician fee schedules. • Methodology for determining fees is not published.	N/A	No information published about updates.

[52] https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=ch7_clinic.pdf&URI=Manuals/ch7_clinic.pdf; https://www.ctdssmap.com/CTPortal/Provider/Provider-Fee-Schedule-Download; https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=ch7_clinic.pdf&URI=Manuals/ch7_clinic.pdf; discussions with DMAS; information provided to Myers and Stauffer by DSS January 2024.

[53] https://www.maine.gov/sos/cec/rules/10/144/ch101/c2s102.docx

[54] https://www.mass.gov/doc/rates-for-restorative-services-effective-april-1-2022-0/download

Clinic – Rehabilitation						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
			encounter, or day.			
New Jersey[55]	Prospective.	Fee schedule.	CPT/HCPCS defined units per quarter hour, hour, encounter, or day.	See Physician and Outpatient discussion.		No information published about updates.
New York[56]	Prospective.	Fee schedule.	CPT/HCPCS defined units per quarter hour, hour, encounter, or day.	Methodology for determining fees is not published.	N/A	No information published about updates.
Oregon[57]	Prospective.	Fee schedule.	CPT/HCPCS defined units per quarter hour, hour, encounter, or day.	Methodology for determining fees is not published.	N/A	No information published about updates.
Medicare [58]	See Medicare Physician and Outpatient Services discussion.					

[55] https://www.njmmis.com/hospitalinfo.aspx; https://www.njmmis.com/downloadDocuments/CPTHCPCSCODES2024.pdf
[56] https://www.emedny.org/ProviderManuals/RehabilitationSrvcs/PDFS/Rehabilitation_Fee_Schedule.pdf
[57] https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1719
[58] https://www.cms.gov/medicare/physician-fee-schedule/search?Y=1&T=4&HT=0&CT=2&H1=90474&C=96&M=5

Dental Services – Adult and Pediatric

Dental Services – Adult and Pediatric						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[59]	Prospective Dental Fee Schedule.	CDT and CPT.	Service or visit as billed and defined by procedure code (CDT/CPT).	Fees were originally based on moderate and reasonable rates prevailing in the respective communities where the service is rendered. Dental service codes added in 1996, and additional codes added from 2004-2008.	New services rates set at approximately 60% of what commercial payers pay. Dental hygienists receive 90% of the dentist fee schedule for the services they provide.	• Rates were increased in 2007 for 20 of the most common codes. • 2015 – There was a 2.5% cutback of fees for children's services (currently in place). • 7/1/2022 rates increased for endodontic services to children and adults by 25%.
Maine[60]	Prospective Dental Fee Schedule.	CDT.	Service or visit as billed and defined by	Diagnostic, endodontic, periodontics, preventive, and limited orthodontic services based on 67% of Commercial	• Separate benchmarks for orthodontia.	Annual inflation adjustment to all rates based on the Consumer

[59] Documentation provided by DSS to Myers and Stauffer.
[60] *Mainecare Benefits Manual*, Chapter II, Section 25, pp. 17-18.

Dental Services – Adult and Pediatric						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
			procedure code (CDT).	Median Benchmark or 133% of the Medicaid State Average Benchmark. • Adjunctive, oral and maxillofacial surgery, orthodontics, prosthodontics, and restorative services based on 50% of Commercial Median Benchmark or 100% of the Medicaid State Average Benchmark.	• Codes for sedation are 50% of the Commercial Median Benchmark for the CDT code that represent the first 15 minutes of sedation.	Price Index for dental services in U.S. city average, all urban consumers, seasonally adjusted to adjust rates to the current year. Benchmarks are updated every two years using claims from the most recent Maine state fiscal year and the most current rates available from other Medicaid States.
Massachusetts [61]	Prospective Dental Services fee schedule.	CDT.	Service or visit as billed and defined by procedure code (CDT).	Methodology is not published.	N/A	No update schedule.

[61] https://www.mass.gov/doc/101-cmr-314-rates-for-dental-services/download

Dental Services – Adult and Pediatric						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
New Jersey[62]	Prospective Dental Services Fee Schedule.	CDT.	Service or visit as billed and defined by procedure code (CDT).	Methodology for fee schedule is not published.	N/A	No update schedule.
New York[63]	Prospective Dental Services Fee Schedule.	CDT.	Service or visit as billed and defined by procedure code (CDT).	Methodology for fee schedule is not published.	N/A	No update schedule.
Oregon[64]	Prospective Dental Services Fee Schedule.	CDT.	Service or visit as billed and defined by procedure code (CDT).	A percentage of commercial insurers' fees, provider usual and customary fees, or through comparison with other state Medicaid reimbursement rates.	N/A	No update schedule.
Medicare[65] Not a covered benefit.						

[62] https://nj.gov/humanservices/providers/rulefees/regs/rulesfiles/NJAC%2010_56%20MANUAL%20FOR%20DENTAL%20SERVICES.PDF
[63] https://regs.health.ny.gov/content/section-5353-state-reimbursement
[64] https://www.oregon.gov/oha/HSD/OHP/Tools/ffs-medical-dental-rates.pdf
[65] In general, Medicare Parts A or B do not pay for any expenses incurred for coverage, items, and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth. Medicare has paid for dental services in some clinical circumstances when dental services are inextricably linked to the clinical success of specific covered medical services. In the 2023 Physician Fee Schedule final rule, CMS codified that Medicare payment under Parts A and B could be made when dental services are furnished in either the inpatient or outpatient setting under particular kinds of circumstances. Source: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-proposed-rule#:~:text=Specifically%2C%20in%20CY%202023%2C%20CMS,necessary%20treatments%20prior%20to%20organ

Federally Qualified Health Centers (FQHCs)

FQHCs[66]						
Payer[67]	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[68]	Prospective Fee Schedule.	Cost reports from 1999 and 2000.	Per encounter, separate rates for medical, behavioral health, and dental services.	**BIPA PPS Methodology:** Encounter based rates were established using a baseline encounter rate for each FQHC in existence during FY 1999 and 2000. The two-year average from these reports using cost per encounter is set as the baseline encounter rate.	Adjustments to rates for changes in the scope of services. Effective 5/1/2022, the cost of long-acting, reversible contraceptive devices will be paid separately.	Annually, the percentage increase in Medicare economic index (MEI) is applied to the base rate.
Maine[69]	Prospective Fee Schedule.	See CT regarding BIPA calculations.	Per encounter, single rate.	**APM Methodology:** The rebasing methodology follows BIPA regulations and uses FY2018 and 2019 data, adjusted to take into account any increase or decrease in the scope of services furnished during the period from 2020-2022. Providers may also bill for out-of-scope services delivered on the same day as the eligible PPS scope services.	See CT regarding BIPA calculations.	See CT regarding BIPA calculations.

[66] Each of the states uses the BIPA methodology as described for Connecticut. In those cases where states have slightly modified their BIPA calculations, those approaches are noted. All the states with the exception have in place at least one APM. States are required to compare APM rates to those established under BIPA, and pay at least as much as the BIPA rates would have paid annually. In addition, states using risk based managed care pay "wrap" payments to FQHCs to ensure payments equal at least what would have been paid under the BIPA Methodology.

[68] https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=ch7_FQHC.pdf&URI=Manuals/ch7_FQHC.pdf; Attachment 4.19-B, Addendum 5a, Page 1 to State Plan.

[69] Maine Legislature. An Act to Improve the Quality and Affordability of Primary Health Care Provided by Federally Qualified Health Centers. May 8, 2022; https://www.maine.gov/sos/cec/rules/10/144/ch101/c2s031.docx, Supplement 1 to Attachment 4.19-B, Page 1.3, Amendment TN 23-0003 to State Plan.

FQHCs[66]						
Payer[67]	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				FQHCs have the option of obtaining a separate billing number for the limited purpose of FFS billing and reimbursement for such services as x-ray, EKG, inpatient hospital visits and other Medicare defined non-FQHC services that are billable under Medicare Part B. If a center chooses to bill fee for service for Medicare defined non-FQHC services, it may not report costs related to these services on its MaineCare cost report.		
Massachusetts[70]	Prospective Fee Schedule.	Se CT regarding BIPA calculations. HCPCS fee schedules are used for APMs.	Per encounter, separate rates for medical, behavioral health, and dental services.	**BIPA PPS Methodology.** Of note: • 1999 and 2000 per visit costs were adjusted for reasonableness by capping the PPS rates at the 50th and 75th percentile of 1999 and 2000 costs reported by FQHCs that existed at the time and continue to be enrolled with MassHealth as community health centers as of June 30, 2021. **APM Methodology:** • Pays FQHCs for medical and behavioral health services on the basis of HCPCS codes and the Community Health Center fee	See CT regarding BIPA methodology.	See CT regarding BIPA methodology.

[70] Mass.gov. 101 CMR 304.00: Rates for Community Health Centers. July 7, 2023.

FQHCs[66]						
Payer[67]	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				schedule; rates are reconciled to BIPA rates quarterly. • For dental services, fees are based on the Dental Fee Schedule, plus an FQHC dental enhancement rate add-on, which when added to the dental enhancement fee rate, totals $110 per dental visit. • Calculation of wrap payments: "visit" will include all individual medical visits, individual mental health visits, individual behavioral health visits, nurse-midwife medical visits, group medical visits, and group behavioral health visits; provided however, that group medical visits and group behavioral health visits will amount to 20% of a visit. For the purposes of calculating the dental reconciliation wrap APM payment, "visit" will include all individual dental visits. Each FQHC is paid, in the aggregate and on a quarterly basis, an amount at least equal to what the FQHC would have been paid under PPS. The total APM is		

FQHCs[66]						
Payer[67]	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				inclusive of the claims-based APM payments and reconciliation wrap APM payments.		
New Jersey[71]	Prospective Fee Schedule.	See CT regarding BIPA methodology. Current Medicaid fee schedule for APMs or as noted.	Per encounter, separate rates for medical, behavioral health, and dental services.	Three APM Methodologies; FQHC must opt in to an APM approach; once an FQHC has opted out of an APM, it is no longer eligible to receive an APM. **Alternative Payment Methodology #1** • The greater of the FY 1999 or FY 2000 final settled Medicaid cost report, or • The final settled Medicaid costs for the FY 1999 and FY 2000 cost reports that are adjusted as follows: ○ FQHC administrative reimbursement based on total allowable costs rather than allowable direct patient care costs, subject to an administrative cost limit	See CT regarding BIPA methodology. The BIPA and APM encounter rates may be adjusted for a change in scope of services.	See CT regarding BIPA methodology. The APM encounter rate is adjusted for inflation using the percentage increase in the MEI applicable to primary care services. Rates are updated annually.

[71] Medicaid.gov. New Jersey State Plan Amendment 20-0015. September 15, 2023; https://www.medicaid.gov/sites/default/files/2023-09/NJ-20-0015.pdf

FQHCs[66]						
Payer[67]	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				of 30% of total allowable cost. ○ FQHC reimbursement for productivity standards that are based on the standards applied by Medicare for cost reporting purposes. ○ The overall per encounter limit on FQHC Medicaid costs increased from 110% of the Medicare limit to the Medicare limit plus $14.42. ○ Allowable costs determined using the Medicare principles of reasonable cost reimbursement. **Alternative Payment Methodology #2: Deliveries and Ob/GYN Surgeries** FQHCs that elect this APM are paid for deliveries and Ob/GYN surgeries, at the higher of the Medicaid fee schedule rate for the particular code or the FQHC's PPS encounter rate. Reimbursement for surgical assistants		

FQHCs[66]						
Payer[67]	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				will be at the Medicaid fee schedule rate for the particular code. Antepartum, postpartum and post-surgical encounters provided to Medicaid/NJ FamilyCare fee-for-service beneficiaries that are not included in the delivery code reimbursement, will be reimbursed to the FQHC at the PPS encounter rate. **Alternative Payment Methodology #3: APM III** • The APM III will pay a rate equivalent to 100 percent of the Medicare FQHC base payment rate, adjusted for each FQHC based on the facility's location (referred to as FQHC geographic adjustment or FQHC GAF) plus $19.35. • The FQHC APM III rate will be calculated as follows: (Medicare Base PPS payment rate x FQHC GAF) + $19.35 = APM rate 3) • APM encounter rate shall be updated annually using the MEI.		

FQHCs[66]						
Payer[67]	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
New York[72]	Prospective Fee Schedule.	See CT regarding BIPA methodology. Current APG fee schedule for APM.	Per encounter, for each of medical, behavioral, and dental services.	**BIPA Methodology** Of note, all-inclusive rates are based on the lower of the facilities' allowable operating cost per visit or the peer group ceiling plus allowable capital cost per visit. **Alternative Payment Methodology** FQHCs can participate in the APG methodology. APG methodology provides opportunity to bill for certain primary care enhancements that are built into rates, such as diabetes, asthma education, and expanded hour access. Effective April 1, 2023, under an APM methodology, eligible FQHCs can receive an additional payment to preserve and improve beneficiary access to care and avoid loss of services in areas of concern. The annual amount of the additional will not be subject to subsequent adjustment or reconciliation.	Annually, capital costs are reconciled, and reimbursement is adjusted accordingly.	APG rates were periodically increased for the operating cost component of all-inclusive rates and the rates of payment for the group psychotherapy and individual off-site services for hospital based FQHCs. The increases in Medicaid rates of payment for these providers were in addition to the standard Medicaid operating cost component calculation, which is increased by the

[72] Medicaid.gov. New York State Plan Amendment NY-23-0086. September 20, 2023;https://www.medicaid.gov/sites/default/files/2023-09/NY-23-0086.pdf

FQHCs[66]						
Payer[67]	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				The APM will be agreed to by the Department of Health and the FQHC/RHC and will result in payment to the FQHC/RHC of an amount that is at least equal to the PPS rate. FQHCs/RHCs that do not choose an APM will be paid at their PPS per visit rate.		percentage increase in the Medicare Economic Index every October 1.
Oregon[73]	Prospective Fee Schedule.	See CT regarding BIPA methodology. APM PMPM calculations based on historical cost and utilization information.	Per encounter, for Medical, Dental, and Mental Health/Substance Use Disorder Services. Dental services and behavioral health services are carved out of the APM.	**Alternative Payment Methodology** The Advanced Payment and Care Model (APCM) makes payments on a PMPM basis. APMs let practices earn more rewards in exchange for taking on risk related to patient outcomes. The program is intended to incent a significant transition in patient-centered care that will result in a reduction in traditional, billable patient visits. The APM converted the clinic's current PPS rate into an equivalent Per Member Per Month (PMPM) rate using historical patient utilization and the medical-only cost base rate for	See CT regarding BIPA methodology. For APMs, there is a phased approach to assessing penalties for poor quality performance.	See CT regarding BIPA methodology. No information available about update to APM rates. Quality target values are updated each year

[73] https://www.nachc.org/wp-content/uploads/2023/03/Oregon-FQHC-APM-December-2017.pdf; https://www.oregon.gov/oha/HSD/OHP/Tools/APM%20FAQs.pdf; https://www.oregon.gov/oha/HSD/Medicaid-Policy/StatePlans/Medicaid-State-Plan.pdf, https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1733

FQHCs[66]						
Payer[67]	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				the specific clinic. The base rate is determined as follows: • If a clinic PPS rate = $100/medical encounter, and if the clinic served 5000 Medicaid patients at an average of 3.0 encounters/patient, for total Medicaid medical visit revenue of $1,500,000 (excluding dental and mental health revenue), the APM rate is based on $ 1,500,000 / 5000 = $300 per patient, per year. The clinic's PMPM is equal to $300/12 = $25 PMPM. • The conversion of the clinic's PPS rate to a PMPM includes estimates of the number of fee-for-service beneficiaries that will be served by the clinic as well as the average number of encounters/visits that will be delivered. The APM will be adjusted annually by the MEI as published in the Federal Register. • In comparing the APM payments to the BIPA payments, the FQHC participating in APM is required to report all payments received for the provision of health services to Oregon Health Plan		

FQHCs[66]						
Payer[67]	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				members, including capitation and any and all payments received by the FQHC/RHC from private insurance or any other coverage, as well as including Medicare MCO supplemental payments, Medicare Advantage Managed Care Organizations (MCO), any Third Party Resource(s) (TPR), total payments for all services submitted to the Prepaid Health Plans (PHP), including laboratory, radiology, nuclear medicine, and diagnostic ultrasound; and excluding any bonus or incentive payments. OHA tracks five metricsto hold FQHCs accountable for the quality of care: Colorectal cancer screening Depression Screening Diabetes Poor Control Weight assessment and counseling in children and adolescents Hypertension		
Medicare[74]	Prospective.	100% of reasonable costs	Per visit.	Medicare payment is made based on a national rate which is adjusted based on the location of where the	The FQHC PPS base rate is adjusted for each FQHC by the	PPS rate is updated annually by the

[74] https://www.cms.gov/medicare/payment/prospective-payment-systems/fqhc_pps, https://www.cms.gov/files/document/r12267cp.pdf

FQHCs[66]						
Payer[67]	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
		established as of 10/1/2014.	Detailed Healthcare Common Procedure Coding System (HCPCS) coding with the associated line item charges listing the visit that qualifies the service for an encounter-based payment and all other FQHC services furnished during the encounter are also required.	services are furnished. The rate is increased by 34.16 percent when a patient is new to the FQHC, or an Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV) is furnished.	FQHC Geographic Adjustment Factor (GAF), based on the Geographic Practice Cost Indices (GPCIs) used to adjust payment under the Physician Fee Schedule (PFS). The FQHC GAF is adapted from the work and practice expense GPCIs and are updated when the work and practice expense GPCIs are updated for the PFS. For CY 2024, the FQHC PPS GAFs have been updated in order to be consistent with the statutory requirements.	FQHC market basket. The 2024 base payment rate reflects a 4.7 percent increase above the 2023 base payment rate of $187.19.

Home Health

Home Health						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[75]	Prospective.	Fee schedule.	Revenue code. Therapists – per hour. Nursing – per unit or per visit.	State does not have documentation regarding how the methodology for these services was determined. Rates are established for: • Nursing care. • Home health aide. • Home health aide with instrumental activities of daily living. • Physical therapist. • Speech therapist or speech pathologist. • Occupational therapist. Rate updates have included the following: <u>Complex Nursing Care</u> <u>Effective dates</u> • 10/1/2017 – Increase payment for claims with TG modifier from 45.7% to 47.2% of rates for S9123 and S9124 with modifiers and S9124 with modifiers[76]	Medicaid applies a cost effectiveness test comparing costs of home health with nursing facility when prior approving services. In addition to the fee schedule rate, effective 8/1/2021, the State pays a value-based payment (VBP) rate add-on of up to 1% of the applicable rate for any home health service if specific conditions are met.	No set update schedule.

[75] https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=ch7_hh.pdf&URI=Manuals/ch7_hh.pdf; Attachment 4-19-B State Plan, page 1(a)v.
[76] https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=PB17_60.pdf&URI=Bulletins/PB17_60.pdf

Home Health						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				• 7/1/2021 – 30% increase for pediatric complex care[77] • 7/1/2021 – 1.7% increase for pediatric complex care skilled services [78] • 1/1/2024 – Increase to adult complex care for parity to pediatric rates[79] <u>HHA increases for minimum wage effective dates</u> • 1/1/2019 – 2%[80] • 10/1/2019 1%[81] • 9/1/2020 – 2.3% [82] • 7/1/2022 5.2%[83] • 7/1/2023 – 4.9%[84] • 8/1/2021 – 6% [85]		
Maine[86]	Prospective.	Fee schedule.	CPT/HCPCS.	Methodology for determining fees is not published.	N/A	Rate study expected in 2024.

[77] https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=pb22_40.pdf&URI=Bulletins/pb22_40.pdf; https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=pb22_02.pdf&URI=Bulletins/pb22_02.pdf
[78] https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=pb21_54.pdf&URI=Bulletins/pb21_54.pdf
[79] https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=pb23_75.pdf&URI=Bulletins/pb23_75.pdf
[80] https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=pb18_61.pdf&URI=Bulletins/pb18_61.pdf
[81] https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=PB19_61.pdf&URI=Bulletins/PB19_61.pdf
[82] https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=pb20_77.pdf&URI=Bulletins/pb20_77.pdf;
[83] https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=pb22_49.pdf&URI=Bulletins/pb22_49.pdf
[84] https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=pb23_49.pdf&URI=Bulletins/pb23_49.pdf
[85] https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=pb22_03.pdf&URI=Bulletins/pb22_03.pdf
[86] https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/TAP%20schedule%20consultation.pdf

Home Health						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Massachusetts[87]	Prospective.	Fee schedule.	Per visit for all services except home health aide, for which billing is in 15-minute increments. Visits are up to eight 15-minute increments	Fee schedule for the following services: • Home health aide • RN/LPN • OT • PT • Speech/language therapy. Statewide rates	EOHHS uses data from the most recent Cost Report to set rates.	No information published about updates.
New Jersey[88]	Prospective.	Revenue codes, based on cost reports.	15-minute intervals	Fee schedule for the following services: • Skilled nursing visit • Home health aide visit • Speech therapy visit • Physical therapy visit • Occupational therapy visit • Medical social service visit	Uses both statewide and provider-specific rates.	Fee schedule effective 1/1/2000 updated annually based on CMS Home Health Market Basket Index.
New York[89]	Prospective.	Cost Based.	Billed per visit; HHA rate is per hour.	Episodic Payment System (EPS), based on a price for 60-day episodes of care. Statewide episodic base rate was calculated using 2009 data; rate is adjusted by individual CMI (based on OASIS data) and regional wage index (applied to labor portion of the	Outlier adjustments for high utilization cases exceeding cost threshold for each case mix group. Payments are proportionately reduced to reflect	No information published about updates.

[87] https://www.mass.gov/doc/957-cmr-6-cost-reporting-requirements/download, https://www.mass.gov/doc/101-cmr-350-rates-for-home-health-services/download
[88] https://nj.gov/humanservices/providers/rulefees/regs/NJAC%2010_60%20Home%20Care%20Services.pdf
[89] https://www.health.ny.gov/facilities/long_term_care/reimbursement/chha/

Home Health						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				rate) for each of 10 labor markets).	episodes of care totaling less than 60 days.	
Oregon[90]	Prospective.	Revenue code by type of service.	Per visit.	Six visit types: • Skilled nursing visits • Home Health aide • Occupational therapy • Physical therapy • Speech-language pathology • Medical and surgical supplies Payment for services is a statewide fee schedule based upon 74% of the most recently accepted Medicare Cost reports. Medical supplies are paid based on acquisition cost	N/A	Recalculates rates every other year. Last update 1/1/2019. No information published about future updates.
Medicare[91,]	Prospective.	Patient-driven groupings model (PDGM); there are 432 case mix groups.	30-day episode of care. $2,010.69—adjusted for case mix and geographic	Standardized amount, bundled for 30-day period and adjusted by PDGM weights.	Comorbidity adjustment (low, medium, high) rural add-on, case mix adjustment and wage index adjustments.	Annually, on January 1, based on changes to the Home Health Agency (HHA) Market Basket (base year 2016).

[90] https://oregon.public.law/rules/oar_410-127-0060

[91] https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/home-health-pps-fact-sheet-icn006816.pdf; https://www.forvis.com/forsights/2023/02/2023-home-health-final-payment-rule#:~:text=CY%202023,-National%20Standardized%2030&text=The%20aggregate%20increase%20of%200.7,ratio%20used%20for%20outlier%20payments

Home Health						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
			differences in wages.		Additional outlier payment for high-care cases; outlier payments are available. Providers that fail to meet Home Health Quality Reporting Program (QRP) requirements, subject to 2% reduction of market basket increase.	HHAs that do not report quality data to CMS receive a reduction of two percentage points to the market basket index.

Hospice

Hospice						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Medicaid – General	Payment for hospice services is based on the Medicaid hospice rates published annually in a memorandum issued by CMS. These Medicaid hospice rates are effective from October 1 of each year through September 30 of the following year. Payment for hospice care will be made at predetermined rates for each day in which a beneficiary is under the care of the hospice. The daily rate is applicable to the type and intensity of services furnished to the beneficiary for that day. Consistent with sections 1902(a)(13)(b) and 1902(a)(30)(A) of the Social Security Act, states retain their flexibility to pay providers more than the established minimum payment published in the Medicaid Hospice Payment Rate letter. Rates are set for revenue codes or based on HCPCS codes, based on per diems, max per four hours, and per hour basis. For each day that an individual is under the care of a hospice, the state pays the hospice an amount applicable to the type and intensity of the services furnished to the individual for that day. For continuous home care, the amount of payment is determined based on the number of hours of continuous care furnished to the beneficiary on that day. A description of each level of care is as follows: • **Routine Home Care**: The state pays the hospice one of two-tiered per diems, as set by CMS based on a beneficiary's length of stay, with a higher rate for the first 60 days of hospice care and a lower rate starting on day 61. The routine home care rate is paid for each day the patient is under the care of the hospice and another hospice rate is not paid. This rate is paid without regard to the volume or intensity of services provided on any given day. • **Continuous Home Care**: The state pays the hospice at the continuous home care rate when continuous home care is provided. The continuous home care rate is divided by 24 hours in order to arrive at an hourly rate. A minimum of eight hours per day must be provided. The state pays the hospice for every hour or part of an hour of continuous care furnished up to a maximum of 24 hours a day. • **Inpatient Respite Care**: The state pays the hospice at the inpatient respite care rate for each day the beneficiary is in an approved inpatient facility and is receiving respite care. The state pays for respite care for a maximum of five days each admission for respite, including the date of admission but not counting the date of discharge. The state pays for the sixth and any subsequent days at the routine home care rate. • **General Inpatient Care**: The state pays at the general inpatient rate when general inpatient care is provided. Outside of the payments made for the various levels of care described above, the following payment provisions are also made for hospice services. • **Service Intensity Add-on (SIA) Payment**: The state pays the SIA for visits made by a social worker or a registered nurse, when provided during routine home care in the last seven days of life. The SIA payment is in addition to the routine home care rate. The				

Hospice						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
	SIA payment will be equal to the continuous home care hourly rate, multiplied by the hours of nursing or social work provided (up to four hours total) that occurred on the day of service. The SIA payment will also be adjusted by the appropriate hospice wage index. • **Hospice Nursing Facility Room and Board**: Hospice nursing facility room and board per diem rates are reimbursed to the hospice provider at a rate equal to 95% of the skilled nursing facility rate, less any Post Eligibility Treatment of Income amount (amount an individual in an institution is able to contribute to cost of his/her own care) for Medicaid clients who are receiving hospice services. The hospice provider is responsible for passing the room and board payment through to the nursing facility. • **Optional Provisions**: States can elect to implement the hospice payment cap and/or a 4 or less percentage point reduction to the market basket index for lack of quality reporting. Federal regulations at 42 USC § 1396a(a)(13)(B) require that each state's Medicaid hospice rates be no lower than, and be generated using the same methodology as, the Medicare hospice rates. Medicare hospice rates are calculated using two CMS-provided figures – the wage component (which is subject to geographic index) and a non-weighted amount – for each service type. The wage component is first multiplied by a wage index, which is standardized to "1", and is intended to capture differences in labor prices on a county-by-county basis throughout the country. After applying the wage index, CMS adds that figure to the non-weighted amount to calculate the rate for the specific service for the county. Federal regulations at 42 USC § 1395f(i)(5)(A)(i) require that full payment to a hospice provider is contingent upon that provider's compliance with federal quality reporting standards.				
Connecticut[92]	Prospective.	See Medicaid General above.				
Maine[93]	See Medicaid General in Hospices Section above.			Payment is the Maine Rate, or the lowest amount allowed by Medicare for the four levels of care. For routine home care only, the lowest rate of Maine is 123% of the Medicare rate.	See Medicaid General discussion.	
Massachusetts[94]	See Medicaid General discussion.					

[92] Attachment 4.19-B, page 2 (b).
[93] https://www.maine.gov/sos/cec/rules/10/ch101.htm
[94] https://www.mass.gov/regulations/130-CMR-437000-hospice-services

Hospice						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
New Jersey[95]	See Medicaid General discussion.					
New York[96]	See Medicaid General discussion.					
Oregon[97]	See Medicaid General discussion.					
Medicare[98]	Prospective.	Fee schedule.	Per diem.	Four levels of care: • Routine Home Care • Continuous Home Care • Inpatient Respite Care • General Inpatient Care Levels of care are adjusted by location and intensity of services provided.	There is a statutory aggregate cap-on service. The Hospice QRP was established in fiscal year (FY) 2012 and includes 10 measures.	Annual update based on the Inpatient prospective payment system (IPPS) Hospital Wage Index. Hospices that do not report quality data to CMS receive a two-percentage point reduction in their annual payment update, increasing to four percentage points in 2024.

[95] https://www.nj.gov/humanservices/providers/rulefees/regs/rulesfiles/NJAC%2010_53A%20%20HOSPICE%20SERVICES%20MANUAL.PDF
[96] https://www.emedny.org/ProviderManuals/Hospice/PDFS/Hospice%20Manual%20Policy%20Section.pdf
[97] https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=246500
[98] https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospice_final_sec.pdf

Hospital Diagnosis-Related Group (DRG) Organ Acquisition

Hospital DRG Organ Acquisition						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[99]	Manually priced.	Manually priced.	Based on organ transplant type.	Acquisition of certain organs will be reimbursed via an additional payment (to the APR DRG payment amount) on the claim. Acquisition of the heart, liver, kidneys, pancreas, and lungs will be manually priced.		
Massachusetts	No information is available.					
New Jersey[100]	Prospective.	Included in per discharge payment.	Per discharge add-on.	No information is available.		
New York[101]	Prospective.	Included in per discharge payment.	Per discharge add-on.	Includes the cost of the organ acquisition with the DRG payment.	N/A	N/A
Oregon[102]	Prospective	Negotiated	By Service	FFS reimbursement is paid by contract with the Division.	N/A	N/A
Medicare[103]	Retrospective	Reasonable costs	Allowable costs	Medicare reimburses transplant centers for costs associated with the acquisition of organs for transplant to Medicare beneficiaries.	N/A	Annual with DRG update schedule.

[99] https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Medicaid-Hospital-Reimbursement/pb14_79.pdf
[100] https://casetext.com/regulation/new-jersey-administrative-code/title-10-human-services/chapter-52-hospital-services-manual/subchapter-2-policies-and-procedures-related-to-specific-services/section-1052-29-organ-procurement-and-transplantation-services
[101] https://www.health.ny.gov/health_care/medicaid/program/update/2009/2009-11.htm#ben
[102] https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1712
[103] https://oig.hhs.gov/oas/reports/region9/90500034A.pdf, https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R471pr1.pdf

Hospital DRG Organ Acquisition						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				Certified Transplant Centers (CTCs) develop two standard acquisition charges (SACs) based on costs: • SAC for acquiring a living donor organ. • SAC for acquiring a cadaveric donor organ. Hospitals claim and are reimbursed for these costs through submission of their Medicare Part A cost reports. Allowable organ acquisition costs include organ donor and recipient costs before hospital admission for the transplant operation (i.e., pre-transplant services) and hospital inpatient costs associated with the donor. Medicare requires that these costs be reasonable; properly allocated among pre-transplant, post-transplant, non-transplant, and other activities; and supported by appropriate documentation. Fiscal intermediaries to review hospital cost reports and determine the allowability of costs claimed.		

Hospital Outpatient Services

Hospital Outpatient Services						
Payer	**Type of Hospital**	**Basis of payment**	**Unit of payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[104]	All outpatient hospital services.	Ambulatory payment classification (APC) prospective payment system.	CPT/HCPCS.	• Medicare Addendum B (OPPS payment by HCPCS code as modified and reflected in CMAP Addendum B), Addendum A (list of APCs) and Addendum D1 (list of payment status indicators). • Payment is calculated using a conversion factor stipulated in the Medicaid state plan multiplied by the relative weight of the APC. • Conversion factors are adjusted using historical Medicare wage index.	• Reimbursement for observation stays defined as a readmission are reduced by 15%.	• Annual updates to reflect changes in Medicare addenda. • Annual updates to conversion factor per the Medicaid state plan.
Medicare[105]	All outpatient hospital services except Indian Health Services (IHS) and tribal hospitals.	Ambulatory payment classification (APC) prospective payment system.	CPT/HCPCS.	• Medicare Addendum B (OPPS payment by HCPCS code), Addendum A (list of APCs) and Addendum D1 (list of payment status indicators).	• Outlier payments for high cost and complex procedures. • Transitional pass-through payments for new devices, drugs, and biologicals.	Annual updates for payment weights, wage adjustments, outlier payments, and APC group updates.

[104] https://portal.ct.gov/-/media/departments-and-agencies/dss/spas/spa19-y.pdf
[105] https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient

Hospital Outpatient Services						
Payer	**Type of Hospital**	**Basis of payment**	**Unit of payment**	**Methodology**	**Adjustments**	**Update Schedule**
				• Payment is calculated using a conversion factor multiplied by the relative weight of the APC. • Conversion factors are adjusted by current Medicare wage index.		

Independent Audiology and Speech and Language Pathology

Independent Audiology and Speech and Language Pathology						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[106]	Prospective.	Fee schedule.	CPT/HCPCS defined units per quarter hour, hour, encounter, or day.	State does not have documentation regarding how the methodology for these services was determined; fees were established in either 1986 or 2000. In 2013, DSS added several audiology services codes with fees based on the then current Medicaid physician office and outpatient rate (57.5% of the 2007 Medicare physician fee schedule). Since 2013, codes that are added as part of the HIPAA compliance updates are priced at 57.5% of the Medicare PFS.	N/A	Changes in 2015 to account for change in the daily quantity limits allowed for reimbursement. Last update 1/1/2022. No set update schedule.

[106] https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=ch7_ind_ther.pdf&URI=Manuals/ch7_ind_ther.pdf; Attachment 4.19-B to State Plan; information provided to Myers and Stauffer by DSS January 2024.

Independent Audiology and Speech and Language Pathology						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Maine[107]	Prospective.	See Physician and Outpatient discussion.	CPT/HCPCS defined units per quarter hour, hour, encounter, or day.	52 percent of 2005 Medicare PFS; services added to fee schedule are at 70% of Medicare rate in the year CMS assigned a rate for that code. • 70 percent of 2009 Medicare. • For speech therapy, 69 percent of 2018 Medicare for agencies, and 90 percent of the agency rate for independents.	N/A	3/1/2023.
Massachusetts[108]	Prospective.	Fee schedule.	CPT/HCPCS defined units per quarter hour, hour, encounter, or day.	Methodology for determining fees is not published.	With the exception of services provided by rehabilitation centers and speech and hearing centers, the fee for any service provided out of the office is 115% of the respective in-office fee.	No information published about updates.
New Jersey[109]	Prospective.	Fee schedule.	CPT/HCPCS defined units per quarter hour, hour,	Methodology for determining fees is not published.	Rates for adults and children, specialists and non-specialists.	No information published about updates.

[107] https://www.maine.gov/dhhs/oms/about-us/projects-initiatives/Maine-rate-system-reform, https://www.maine.gov/dhhs/oms/providers/provider-bulletins/2023-revised-rates-speech-and-hearing-services-cr-115541-2023-05-22
[108] https://casetext.com/regulation/code-of-massachusetts-regulations/department-130-cmr-division-of-medical-assistance/title-130-cmr-413000-speech-and-hearing-center-services/section-413406-maximum-allowable-fees
[109] https://www.njmmis.com/hospitalinfo.aspx

Independent Audiology and Speech and Language Pathology						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
			encounter, or day.			
New York[110]	See Physician and Outpatient discussion.			80% of Medicare.	N/A	Last updated 10/1/23. No information published about updates.
Oregon[111]	See Physician and Outpatient discussion.					
Medicare [112]	See Physician and Outpatient discussion.					

Independent Physical Therapy and Occupational Therapy

Independent Physical Therapy and Occupational Therapy						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[113]	Prospective.	HCPCS.	CPT/HCPCS defined units per quarter hour, hour, encounter, or day.	• Fee schedule was not included in the 2008 fee schedule updates, and there is no documentation to explain why. Several services are still priced at the 1999 rate and there is no documentation as to how that rate was set. • New codes or services added since 2017 are priced the same as the Medicaid physician fee	N/A	• No rate updates have been implemented except for HIPAA compliance updates or addition of services.

[110] https://www.emedny.org/ProviderManuals/HearingAid/PDFS/HearingAid_Policy_Guidelines.pdf, ttps://regs.health.ny.gov/content/section-50531-audiology-hearing-aid-services-and-products; https://www.emedny.org/ProviderManuals/RehabilitationSrvcs/PDFS/Rehabilitation_Fee_Schedule.pdf

[111] https://www.oregon.gov/oha/HSD/OHP/Tools/ffs-medical-dental-rates.pdf

[112] https://www.cms.gov/medicare/payment/fee-schedules/physician

[113] https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=ch7_ind_ther.pdf&URI=Manuals/ch7_ind_ther.pdf; Attachment 4.19-B to State Plan; information provided by DSS to Myers and Stauffer January 2024.

Independent Physical Therapy and Occupational Therapy						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				schedule (57.5% of the Medicare PFS).		• No set update schedule.
Maine[114]	Prospective.	Medicare fee schedule.	CPT/HCPCS defined units per quarter hour, hour, encounter, or day.	• Some services 52 percent of 2005 Medicare PFS; services added to fee schedule are at 70% of Medicare rate in the year CMS assigned a rate for that code. • Orthotics—85 percent of 2011 Medicare	N/A	• Last update 2012. • No information published about future updates.
Massachusetts[115]	Prospective.	Fee schedule.	CPT/HCPCS defined units per quarter hour, hour, encounter, or day.	Methodology for determining fees is not published.	With the exception of services provided by rehabilitation centers and speech and hearing centers, the fee for any service provided out of the office will be 115 percent of the respective in-office fee.	No information published about updates.
New Jersey	Prospective.	Fee schedule.	CPT/HCPCS defined units per quarter hour, hour, encounter, or day.	Methodology for determining fees is not published.	Rates for adults and children, specialists and non-specialists	No information published about updates.

[114] https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.maine.gov%2Fsos%2Fcec%2Frules%2F10%2F144%2Fch101%2Fc3s085.doc&wdOrigin=BROWSELINK, https://www.maine.gov/sos/cec/rules/10/ch101.htm

[115] https://www.mass.gov/doc/rates-for-restorative-services-effective-april-1-2022-0/download

Independent Physical Therapy and Occupational Therapy						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
New York [116]	Prospective.	Fee schedule.	CPT/HCPCS defined units per quarter hour, hour, encounter, or day.	Methodology for determining fees is not published.	Pays only for services provided in a private office setting, if services provided in any other setting, therapist cannot bill Medicaid directly, and would be paid by the medical institution.[117]	No information published about updates.
Oregon[118]	See Physician and Outpatient discussion.					
Medicare[119]	See Physician and Outpatient discussion.					

Independent Radiology

Independent Radiology						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[120]	Prospective.	See Physician and Outpatient discussion.	See Physician and Outpatient discussion.	57.5% of the 2007 Medicare fee schedule. In 2015 the Independent Radiology fee schedule rates were aligned with the Physician Radiology fee schedule.	N/A.	Besides the quarterly HIPAA compliant updates there have not been rate updates to

[116] https://www.emedny.org/ProviderManuals/RehabilitationSrvcs/PDFS/Rehabilitation_Fee_Schedule%20__2016-1.pdf
[117] https://www.emedny.org/ProviderManuals/RehabilitationSrvcs/PDFS/Rehabilitation_Fee_Schedule%20__2016-1.pdf
[118] https://www.oregon.gov/oha/hsd/ohp/pages/fee-schedule.aspx
[119] https://www.cms.gov/medicare/payment/fee-schedules/physician
[120] https://casetext.com/regulation/connecticut-administrative-code/title-17b-social-services/requirements-for-payment-of-home-health-agencies/requirements-for-payment-to-independent-radiology-and-ultrasound-centers/section-17b-262-521-reserved; Attachment 4.19-B to State Plan; information provided by DSS to Myers and Stauffer January 2024.

Independent Radiology						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
						the Independent Radiology fee schedule. No set update schedule.
Maine[121]	See Physician and Outpatient discussion.					
Massachusetts[122]	Prospective.	Medicare PFS.	CPT/HCPCS.	Established using January 2023 Medicare RVUs and conversion factors, adjusted to be budget neutral across groups of services. See Also Massachusetts Physician and Outpatient Services.	N/A.	No information published about updates.
New Jersey	See Physician and Outpatient discussion.					
New York[123]	Prospective.	Medicare PFS.	CPT/HCPCS.	• Benchmarks the physician fee schedule to Medicare: 60% of the Medicare fee schedule for office-based services and 50% of the Medicare fee schedule for facility-based services. • For the 2023-2024 budget, rates are benchmarked to 80% of current Medicare reimbursement rates for non-facility services. (Includes Medicine, Drug, Surgery, and Radiology).	There are fee differentials for certain services when provided in a facility versus an office setting.	No information published about updates.
Oregon[124]	See Physician and Outpatient discussion.					

[121] https://www.maine.gov/sos/cec/rules/10/ch101.htm
[122] https://www.mass.gov/doc/rates-for-radiology-services-effective-august-1-2021-0/download; https://www.mass.gov/doc/notice-of-public-hearing-490/download
[123] https://health.ny.gov/health_care/medicaid/program/update/2023/no13_2023-08.htm
[124] Oregon Medicaid State Plan, Attachment 4.19-B, page 1.

Independent Radiology						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Medicare[125]	See Physician and Outpatient discussion.					

Inpatient Hospital

Inpatient Hospital						
Payer	**Type of Hospital**	**Rate Type**	**DRG Methodology**	**Adjustments**	**Update schedule**	**Per Diem Methodology**
Connecticut[126]	• DRG: All except Chronic Disease, Psychiatric, and Rehabilitation Hospitals. • General acute care hospital claims that group to a behavioral health or rehabilitation DRG are paid per diem, unless no prior authorization is obtained.	• Prospective. • Direct medical education payments are pass-throughs.	• APR-DRG v 41. • Statewide average cost per discharge is adjusted for geographic location and indirect medical education (IME) (0% in 2024) to determine each hospital's base rate. • Peer group adjustments are based on claims: private acute	• The cost outlier threshold is calculated for each DRG based on the average cost for the DRG, plus one standard deviation with a minimum threshold of $30,000. • Outlier amount is paid at 75% of cost above the threshold.	Yearly updates to weights; base rates were updated January 1, 2018, pursuant to state law Sec. 17b-239(i)(1).	• Per diem rates for DRG-excluded services. • When prior authorization is obtained, stays coded to a behavioral health or rehabilitation DRG are paid the hospital's assigned per diem rate rather than the DRG calculation. Additional is

[125] https://cdn.ymaws.com/scct.org/resource/resmgr/Docs/Medicare_Coverage_of_Radiolo.pdf

[126] https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/SPAs/SPA-19-I---Inpt-Hosp-DRG-Grouper-Adj-Factor---Website-Notice.pdf

Inpatient Hospital						
Payer	**Type of Hospital**	**Rate Type**	**DRG Methodology**	**Adjustments**	**Update schedule**	**Per Diem Methodology**
			care, public acute care, and acute care children's hospitals. • National weights established by Solventum (formerly 3M) are used.	• Direct medical education is a quarterly pass-through payment. • Capital payments are paid as add-on payments to claims, after DRG calculations.		paid for child psych. Rates are set in 3 tiers and increase 2% yearly. • Single per diem rate is assigned to Rehabilitation Hospitals • Hospital specific per diem rates for Chronic Disease Hospitals
Massachusetts[127]	• DRG: All except Chronic Disease, Psychiatric, and Rehabilitation Hospitals.	• Prospective; retroactive adjustments for critical access hospitals to equal 101% of costs.	• APR-DRG v 40. • 67.615% of the statewide base rate is labor adjusted; a standard capital payment per discharge is added to the hospital base rate. • State-specific weights are	• Cost Outlier Payment equals the product of the Marginal Cost Factor (60%) and the amount by which the Discharge-Specific Case Cost exceeds the Outlier Threshold ($40,963).	• Yearly	• Per diem rates for DRG-excluded services. • A single per diem rate is assigned for all BH stays, plus an amount ranging from $350 to $3,625 is paid per admission based on

[127] https://www.mass.gov/doc/notice-of-final-agency-action-masshealth-payment-for-in-state-acute-hospital-services-and-out-of-state-acute-hospital-services-effective-october-1-2023-0/download

Inpatient Hospital						
Payer	**Type of Hospital**	**Rate Type**	**DRG Methodology**	**Adjustments**	**Update schedule**	**Per Diem Methodology**
			used, developed by MA. • Clinical Quality Incentive Program is new in Rate Year (RY) 2024: Hospital Quality and Equity Incentive Program. • Hospitals are eligible to apply for a contract if they meet certain intensive care and utilization requirements.	• "Freestanding Pediatric Acute Hospital' (FPAH) is different from "Specialized Pediatric Service Hospital' (the latter has burn unit) • FPAH discharges with a DRG weight >= 3.0 include a 67% positive adjustment to the base rate. • Acute, non-FPAH pediatric bed discharges include a 25% positive adjustment to the base rate. • Acute, non-FPAH, non-pediatric bed discharges include a 6%		admission and member criteria. • Specialty inpatient psychiatric services for eating disorders per diem rate of $1,500. • Single per diem rate assigned for Rehabilitation Hospitals.

Inpatient Hospital						
Payer	**Type of Hospital**	**Rate Type**	**DRG Methodology**	**Adjustments**	**Update schedule**	**Per Diem Methodology**
				positive adjustment to the base rate. • Annual infant outlier payments total $50,000, split between eligible hospitals; annual pediatric outlier payments of $1,000 each are issued. • Base rate adjustments are also made for services such as Essential MassHealth Hospitals, high public payer hospitals, severe ASD/ID with co-occurring MH conditions, and other services or qualifications.		

Inpatient Hospital						
Payer	**Type of Hospital**	**Rate Type**	**DRG Methodology**	**Adjustments**	**Update schedule**	**Per Diem Methodology**
				• 15% of payments are withheld subject to final reconciliation for "Hospital Quality and Equity Incentive Program". The "Clinical Quality Incentives Program" replaced the P4P program in RY 24.		
New Jersey[128]	DRG: All except Special, Psychiatric, and Rehabilitation Hospitals.	Prospective.	• The Statewide per discharge base rate is based upon DRG payments from 2006 claims data, with reductions to exclude outlier payments, payments for alternative levels of care days, payments	• Cost outlier for cases with costs exceeding the threshold, equal to 75 percent of the costs exceeding the cost limit (marginal cost %). • Day outlier of length of stay (LOS) + 1.96 std	Yearly.	• Children's Hospital per diem is cost-based ($3,400). • Hospital-specific per diem rates are set for psychiatric hospitals; government-owned is cost-based.

[128] https://www.njmmis.com/hospitalinfo.aspx

Inpatient Hospital						
Payer	**Type of Hospital**	**Rate Type**	**DRG Methodology**	**Adjustments**	**Update schedule**	**Per Diem Methodology**
			where Medicaid is the secondary payer, hospital based physician payments and utilization review payments. • The Statewide base rate excludes direct and indirect medical education payments. • Add-on amounts of 10% or 15% to the statewide base rate are paid for those qualifying hospitals that provide high volumes of services to Medicaid and other low income patients.	dev of average LOS. • GME payments are made to eligible acute care teaching hospitals on historic allocation amounts. • A number of base rate add-ons are available including an add-on of 10% to the base rate for Critical Access Hospitals. • No incentive payments noted.		• Rehabilitation hospital per diem rates are hospital specific. • The pediatric rehab hospital per diem rate is based on 100% of costs.

Inpatient Hospital						
Payer	**Type of Hospital**	**Rate Type**	**DRG Methodology**	**Adjustments**	**Update schedule**	**Per Diem Methodology**
			• Hospital providing pediatric critical services receives APR-DRG base rate add-on of either 10% or 15%. • The DRG payment for an inpatient claim is calculated by multiplying the statewide base rate, plus add-on amounts if applicable, times the DRG weight. Two categories of outlier payments provide an additional payment above the DRG payment. • The initial statewide base rate is changed			

Inpatient Hospital						
Payer	**Type of Hospital**	**Rate Type**	**DRG Methodology**	**Adjustments**	**Update schedule**	**Per Diem Methodology**
			for annual inflation, until rebasing occurs. • NJ-specific weights recentered based on FFS, MCO, commercial cost data, using calibration factor of 1.604.			
• New York[129]	• DRG: All except Long-Term Acute Care, Psychiatric, Rehabilitation, Critical Access, Chemical Dependency, Cancer, Children's, and Substance Abuse Detox Hospitals.	• Prospective.	• APR-DRG v 41. • State-specific weights effective July 1, 2018. • A statewide base price per discharge is established using base year costs at a per discharge rate. A statewide	• Cost outlier rates are paid up to thresholds that vary based on DRGs.	• Yearly updates of base price; weights updated every 4 years.	• Per diem rates for DRG-excluded services. • A daily billing rate is assigned to Children's Hospitals. ($2,188.13). • Hospital-specific per diem rates for psychiatric hospitals; the operating

[129] https://www.health.ny.gov/facilities/hospital/reimbursement/apr-drg/rates/

Inpatient Hospital						
Payer	**Type of Hospital**	**Rate Type**	**DRG Methodology**	**Adjustments**	**Update schedule**	**Per Diem Methodology**
			budget neutrality factor and institutional-specific wage equalization factor and transitional cost adjustment are applied. Rate add-ons include direct and indirect GME, capital, and non-comparable costs. • Non-comparable costs include inpatient ambulance costs, inpatient costs associated with school of nursing, and hospital-based physicians teaching election amendment costs.			component is case-mix adjusted using APR-DRG service intensity weights that are different from the acute hospital APR-DRG weights. • Adjustments are made to the psychiatric hospitals operating per diem for ages <18, for rural hospitals, for mental retardation diagnoses, and for comorbidity categories; a decreasing variable factor is applied for each day of the stay.

Inpatient Hospital						
Payer	**Type of Hospital**	**Rate Type**	**DRG Methodology**	**Adjustments**	**Update schedule**	**Per Diem Methodology**
			• Psychiatric stays are paid DRG if the hospital has no assigned psychiatric per diem rate.			• The psych non-operating component includes capital and direct GME. • Rehabilitation and Chronic Disease Hospitals are assigned hospital-specific per diem rates.

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID) (Private)

ICF/IID						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[130]	Prospective.	Cost report, reasonable costs. Provider specific, cost based prospective rates.	Per diem.	• Per diem calculated based on reasonable costs, capital rates based on fair rental approach. • Minimum bed per diem is $501.	Facilities can receive a rate increase for capital improvement approved by Department of Developmental Services, for the health or safety of the residents during SFY2025, if rate increases are within available appropriations.	Annual. DMS has submitted SPAs detailing the approach that is used every year to update rates. For SFY25, rates were rebased using 2023 cost report data Providers may receive a rate that is lower than the previous fiscal year's rate, but not lower than the $501 per diem minimum. There is no inflationary factor applied for rates ending June 30, 2025.

[130] https://portal.ct.gov/-/media/departments-and-agencies/dss/health-and-home-care/reimbursement/icf-iid/dss-icf-presentation-july-26-final_.pdf; ;https://portal.ct.gov/-/media/departments-and-agencies/dss/spas/spa-24x-reimbursment-updates-icfiid-changes-methadone-and-ambulance-website-pub-notice.pdf

ICF/IID						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
						For FYE 2026, rates will be based on 2024 cost report, there will be no minimum per diem or inflationary adjustment factor.
Maine[131]	Prospective rates that are cost settled at year end.	Cost report, reasonable costs.	Per Diem.	Three components to the prospective interim rate: • Fixed cost component based on last audited cost report, includes depreciation, amortization of finance costs, amortization of startup costs, real estate and personal property taxes, liability insurance, interest on long-term debt, rental expenses, medical supplies, ICF/IID health care provider tax, mandated direct care staff training program costs, mandated accreditation costs, and approved	• Providers are eligible for an incentive payment for operating in an efficient and economical manner. • Providers are incentivized to maintain high quality to avoid a reduction of the per diem to 90% through a deficiency rate calculation.	Annual. Maine uses the CMS Nursing Home Without Capital Market Basket for inflation adjustments.

[131] https://www.maine.gov/sos/cec/rules/10/144/ch101/c3s050.doc

ICF/IID						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				administrator in training expense. • Variable cost component includes all allowable costs not defined as fixed costs, staff wages, salaries, or authorized staff benefits, incurred in the efficient and economical operation of the facility. Includes home office costs. • Labor cost component includes wages and benefits. • Prospective rates were calculated using the last completed Maine Audit for fixed costs, based on the variable cost component from the prior rate period inflated to year end, and based on actual labor costs from the latest available cost report. • Upon final audit of cost report, Maine determines the actual allowable labor costs, actual allowable variable costs up to the prospective rate, and actual allowable fixed costs. Over- and underpayments are recouped/repaid.	Quality is established by looking at staffing levels, food service standards, or other deficiencies noted during review or that violate licensing requirements. • Providers are reimbursed for specific programs, and for impactful changes in operations upon application and approval by the department. • Providers can request an audit of their costs if it believes that the needs of its residents have increased or	

ICF/IID						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
					decreased considerably. • When a facility is found not to have provided the quality of service or level of care required, reimbursement will be made on ninety (90%) of the provider's per diem rate. This "deficiency rate" will be applied following written notification to the facility of the effective date of the reduced rate for certain service deficiencies.	
Massachusetts[132]	Massachusetts does not contract with private facilities, ICFs are state-run.					

[132] https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MA/MA-19-0031.pdf

ICF/IID						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
New Jersey[133]	Retrospective.	Reasonable Cost	Per Diem.	Interim rates may be calculated as follows: • Cost report based on projected costs for the specific future reporting period, as reviewed by the Department of Human Services • Provider's actual expenditures as reported on the annual cost report, may be adjusted to reflect inflationary increments for major categories of costs. • Interim rates Interim rates are paid based on the prior year rates or another method determined by Medicaid. Retroactive adjustments are made based on allowable costs after cost report submission and review (desk review and/or audit). • The final rate is based on the desk review of the cost report, unless the Department determines it will conduct an audit.	Interim rates are paid, and retroactive adjustments made after cost reports are finalized.	Annual.

[133] https://www.nj.gov/humanservices/dmahs/info/state_plan/Attachment4_Payments_and_Rates.pdf

ICF/IID						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
New York[134]	Prospective.	Cost-based, provider-specific.	Per diem.	Components of rates for ICF/DD services • Allowable costs for the operating component as reported in cost reports. • Alternative operating component, for providers that did not submit a cost report or submitted a cost report that was incomplete for the base year, the final daily operating rate shall be a regional daily operating rate. • Day program services component. • Capital component.	An occupancy adjustment is calculated as the higher of the provider's actual occupancy or 95%; applies to the operating component of the rate.	For years in which the Department does not update rates, a trend factor based on the consumer and producer price indices is applied. Compensation rate increases for direct support personnel may also be applied.
Oregon[135]	Retrospective.	Reasonable costs.	Per Diem.	Rates are based on model budgets which represent 100% of the reasonable costs of an economically and efficiently operated facility of comparable size. There are two cost categories: base costs and labor costs. The facility's model budget rate is adjusted by the most recently available resident occupancy information, not lower than 95		Annual.

[134] https://regs.health.ny.gov/content/subpart-86-11-rate-setting-non-state-providers-intermediate-care-facilities-persons; https://regs.health.ny.gov/content/section-86-113-rates-providers-icfdd-services

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ICF/IID						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				percent of the facility's licensed bed capacity. Modeled budgets are rebased after desk review or audit. A year end settlement rate is established on a retrospective basis, and settlement is based on the lower of the ceiling rate (occupancy adjusted if less than 95%) or the actual per diem cost. Three classes of ICFs/MR: • Small Residential Training Facility (SRTF); 15 or fewer beds • Large Residential Training Facility (LRTF); 16 – 199 beds • Full Service Residential Training Facility (FSRTF); 200 or more beds providing a full range of active medical and day treatment services). Residents are classified into one of three categories using an assessment instrument.		
Medicare	Not a covered benefit.					

Laboratory

Laboratory						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[136]	Prospective.	See Connecticut Physician and Outpatient Services discussion.	See Connecticut Physician and Outpatient Services discussion.	70% of Medicare fee schedule.[137]	See Connecticut Physician and Outpatient Services discussion.	No rate updates since the reduction to 70% in 2015. Fee schedule date of Jan 2023 only incorporates the HIPAA Compliant updates. No set update schedule.
Maine[138]	See Medicare Laboratory Fee Schedule discussion.			70% of 2009 Medicare fee schedule.	See Medicare Laboratory Fee Schedule discussion.	Last update 2010.
Massachusetts, New Jersey	See Medicare Laboratory Fee Schedule discussion, no other information about methodology for determining fees.					
New York[139]	Prospective.	Medicare Laboratory fee schedule.	CPT/HCPCS.	80% of Medicare.	N/A	Last updated 10/1/2023.

[136] Attachment 4.-19-B to State Plan.
[137] Section 1903(i)(7) of the Social Security Act specifies a separate upper payment limit (UPL) for clinical diagnostic laboratory (CDL) services which limits payment to no more than the Medicare rate on a per test basis.
[138] https://www.maine.gov/dhhs/oms/about-us/projects-initiatives/Maine-rate-system-reform;
https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.maine.gov%2Fsos%2Fcec%2Frules%2F10%2F144%2Fch101%2Fc2s055.docx&wdOrigin=BROWSELINK
[139] https://health.ny.gov/health_care/medicaid/program/update/2023/no13_2023-08.htm, https://www.emedny.org/ProviderManuals/Laboratory/PDFS/Laboratory-Policy_Section.pdf

Laboratory						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Oregon[140]	Prospective.	Medicare Laboratory fee schedule.	CPT/HCPCS.	70 % of current Medicare fee schedule		Annual.
Medicare [141]	Prospective.	Medicare fee schedule.	CPT with some bundling.	Clinical Laboratory Fee Schedule rates for most tests are equal to the weighted median of private payer rates, based on data collected every three years-.	None.	Every three years, although annual payment reductions beginning with 2020 rates. 2020-2022 rates based on 1/1/2017 reporting period. 2023-plus based on 1/1/2022-3/31/2022 reporting period.

[140] Oregon State Plan, Transmittal 22-0027, Attachment 4.19B, Page 1.
[141] https://www.cms.gov/medicare/payment/fee-schedules/clinical-laboratory-fee-sch

Medical Supplies (MEDs) and Durable Medical Equipment (DME) [142]

MEDS – DME						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[143]	Prospective.	Medicare fee schedule.	HCPCS.	• 85% of the 2007 Medicare fee schedule. • Fees for new codes are paid at 85% of the current Medicare fee schedule. • In April 2018, to comply with the Cures Act, the rate for the DME items affected and subject to federal law were set at 100% of the 2018 Medicare fee schedule which also incorporated the Medicare Competitive Bidding Program payment amounts. Other existing codes not affected by the federal law remained at the same rate as when they were first introduced onto the DME fee schedule.	N/A	No set update schedule.
Maine[144]	Prospective.	Medicare fee schedule.	HCPCS.	• 100% of the Medicare Fee schedule; if no fee schedule amount, the average cost of the	N/A	Revised the methodology effective January 1,

[142] The CURES act of 2016 prohibits federal Medicaid reimbursement as of 1/1/2018 to states for certain durable medical equipment expenditures that are in the aggregate in excess of what Medicare would have paid for such items. Not all Medicaid DME expenditures are subject to this provision, e.g., does not apply to prosthetics, orthotics, or medical supplies, or for services that Medicaid covers but Medicare does not. Only those items paid on a fee for service basis by Medicaid are covered by this provision. Source: https://www.medicaid.gov/federal-policy-guidance/downloads/smd17006.pdf

[143] Information provided to Myers and Stauffer by DSS January 2024.

[144] https://www.maine.gov/dhhs/oms/providers/provider-bulletins/section-60-medical-supplies-and-durable-medical-equipment-dme-billing-guidance-and, https://casetext.com/regulation/maine-administrative-code/department-10-department-of-health-and-human-services/division-144-department-of-health-and-human-services-general/chapter-101-Maine-benefits-manual-formerly-maine-medical-assistance-manual/chapter-ii-specific-policies-by-service/section-144-101-ii-60-medical-supplies-and-durable-medical-equipment/subsection-144-101-ii-6010-reimbursement

MEDS – DME						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				services from other state agencies. • Incontinence supplies reimbursed at invoice cost +40%. • Also contracts for certain DME. • For rental items, fees are set at the Medicare monthly rate and follow Medicare rental periods, except for oxygen.		2023. For services not on the Medicare fee schedule, the rates are adjusted each year using CPI for all urban consumers for medical equipment.
Massachusetts[145]	Prospective	Fee schedule.	HCPCS.	• Payment based on the Adjusted Acquisition Cost (AAC) which includes the DME/Supplies/other items excluding any shipping, handling, sales tax and insurance costs. + dispensing fee. • Rental: Months 1-3: 10% of purchase price; months 4-13: 75% of purchase price, no further payment after month 13. Rental for power wheelchairs is 15% of new purchase price for months 1-3; 40% for months 4-13.	N/A	No information published about updates.
New Jersey[146]	Prospective.	Fee schedule.	HCPCS.	Methodology for determining fees is not published.	N/A	No information published about updates.

[145] https://www.mass.gov/doc/durable-medical-equipment-regulations/download
https://www.mass.gov/doc/101-cmr-322-rates-for-durable-medical-equipment-oxygen-and-respiratory-therapy-equipment

[146] State Plan, Attachment 4.19B, p.7.; New Jersey 4.19-B Page 7; https://www.nj.gov/dobi/division_insurance/medfees/Exhibit5_FinalEO2Version.pdf

MEDS – DME						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				• For new services not on fee schedule, fee is the lower of customary charges or fee equal to 130% of invoice cost, or 80% of manufacturer's price. • For rentals, if the item is $100 or less, the monthly rental payment is the lower of the billed amount or 20% of the approved purchase price. • If price is more than $100, rental payment is the amount billed or 12% of the purchase price, whatever is less.		
New York [147]	Prospective	Fee schedule.	HCPCS.	Methodology for determining fees is not published. • If no price is listed on the fee schedule, payment is 51% of the acquisition cost. • For rental items, payment is 10% a month, not to exceed full purchase price.	N/A	Updated in April 2022 No information published about updates.
Oregon[148]	Prospective	Fee schedule.	HCPCS.	Based on 2012 Medicare fee schedule, with some modifications: • Ostomy supplies are 93.3% of 2012 Medicare. • Prosthetics and orthotics are 82.6% of 2021 Medicare	N/A	No information published about updates.

[147] https://www.emedny.org/ProviderManuals/DME/PDFS/DME_Policy_Section.pdf
[148] https://www.oregon.gov/oha/HSD/OHP/Policies/122-Changes-010124.pdf

MEDS – DME						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				• Complex rehab items are 88% of 2012 Medicare. • Power wheelchairs are 55 – 58.7%% of 2012 Medicare. • Follows Medicare policies for DME rental. Unspecified items and codes that require manual pricing: 75% of MSRP or acquisition cost plus 20% if MSRP not available		
Medicare[149]	Prospective.	Fee schedule, and DME, prosthetics, orthotics, and supplies competitive bidding program.	HCPCS.	• Medicare Prescription Drug, Improvement, and Modernization Act of 2003 required CMS to phase in a competitive bidding program (CBP) for DME and other items. Under CBP, DME suppliers that were competitively selected and awarded contracts could furnish certain DME items to Medicare beneficiaries in designated competitive bidding areas. The competition process also determined the payments (the single payment amounts (SPA)—for each DME item included in	The DMEPOS competitive bidding program required that Medicare replace the fee schedule payment methodology for selected DMEPOS items with a competitive bid process. In areas that are not competitive bidding areas, 42 Code of Federal Regulations 414.210(g) provides	Annual, July 1.

[149] https://www.cms.gov/medicare/payment/fee-schedules/dmepos; https://www.gao.gov/assets/gao-15-63.pdf; https://www.cms.gov/medicare/payment/fee-schedules/dmepos/fee-adjustment-monitoring; https://www.ssa.gov/OP_Home/ssact/title18/1834.htm

MEDS – DME						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				the CBP. CBP was implemented through several rounds of competitive bidding. Amendments to the Social Security Act required CMS to adjust fee schedules for DME eff 1/1/2016 in areas where competitive bidding was not in effect. Adjustments were based on the average of single payment amounts from CBPs located within the geographic region of the country where the State is located. Regional Single Payment amounts are limited by a floor and ceiling (90 percent and 110 percent of the average of the RSPAs). • As of January 1, 2024, there is a temporary gap in the Competitive Bidding Program. CBP was implemented through several rounds. In the interim, CMS adjusted fees in former Competitive Bidding Areas based on 100% of the single amount for each CBA increased by the projected percentage change in the CPI-Urban for 1/23-1/24. Fees in non-CBA areas are also	authority for making adjustments of the fee schedule for enteral nutrients, equipment, and supplies.	

MEDS – DME						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				adjusted using methodology described in 42 CFR 414.210(g).		

MEDS – Hearing Aid/Prosthetic Eye

MEDS – Hearing Aid/Prosthetic Eye						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**

Connecticut[150]	Prospective.	Medicare fee schedule.	HCPCS defined units per quarter hour, hour, encounter, or day.	• 85% of the Medicare Fee Schedule
				• Hearing aids paid based on the actual acquisition cost plus a dispensing fee, and fee for hearing testing for the purpose of fitting a hearing aid.
				• Price for any supply listed in the fee schedule is lowest of charges or actual acquisition costs plus a dispensing fee up to the maximum allowed by the Department's fee schedule, and includes:
				  ○ Fees for initial measurements, fittings, adjustments, and related transportation costs.
				  ○ Labor charges.
					See MEDS-DME discussion.	No set update schedule.

[150] https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=ch7_MEDS.pdf&URI=Manuals/ch7_MEDS.pdf; information provided to Myers and Stauffer by DSS January 2024.

MEDS – Hearing Aid/Prosthetic Eye						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				○ Delivery costs, fully prepaid by the provider, including any and all manufacturer's delivery charges with no additional charges to be made for packing or shipping. ○ Travel to the client's home. ○ Technical assistance to the client to teach the client, or his or her family, the proper use and care of the supplies. ○ Information furnished by the provider to the client over the telephone.		
Maine[151]	Prospective.	See MEDS-DME discussion.	HCPCS.	See Maine DME discussion. Hearing aids are purchased from the vendor contracted with the State's Division of Procurement services; hearing aid accessories do not have to be purchased from this vendor.	See MEDS-DME discussion.	
Massachusetts[152]	Prospective.	See MEDS-DME discussion.	HCPCS.	The maximum fees are the adjusted acquisition cost of the hearing aid, plus a dispensing fee. Other services are generally paid based on AAC, AAC plus a dispensing fee, or are individually priced.	See MEDS-DME discussion.	

[151] https://www.maine.gov/sos/cec/rules/10/144/ch101/c2s060.docx
[152] https://www.mass.gov/doc/rates-for-hearing-services-effective-november-1-2023-0/download

MEDS – Hearing Aid/Prosthetic Eye						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
New Jersey[153]	Prospective.	See MEDS-DME discussion.	HCPCS.	Fee schedule for new hearing aid paid based on the lower of the following charges. • Provider's usual and customary charges. • Or the charge consisting of the following: ○ Wholesale cost of the instrument, plus ○ Wholesale cost of the ear mold, as per laboratory invoice or laboratory price list, plus ○ Insurance, shipping, and handling costs included as a component of the manufacturer's cost, plus. ○ Wholesale cost of the batteries, plus ○ Dispensing fee of $ 175.00 for a monaural fitting or $ 280.00 for a binaural fitting.	See MEDS-DME discussion.	
New York [154]	Prospective.	See MEDS-DME discussion.	HCPCS.	80% of Medicare.	See MEDS-DME discussion.	Last Updated 10/1/23

[153] https://regulations.justia.com/states/new-jersey/title-10/chapter-64/subchapter-1/section-10-64-1-4/; New Jersey 4.19-B Page 7; https://www.nj.gov/dobi/division_insurance/medfees/Exhibit5_FinalEO2Version.pdf

[154] NY State Plan, Attachment 4.,19B, New York 5(b) page 2037; https://health.ny.gov/health_care/medicaid/program/update/2023/no13_2023-08.htm

MEDS – Hearing Aid/Prosthetic Eye						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Oregon[155]	Prospective.	Medicare fee schedule, other fee schedule.	HCPCS.	Provider's acquisition costs.	See MEDS-DME discussion.	Annual.

MEDS – Medical Surgical Supplies

MEDS – Medical Surgical Supplies						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[156]	Prospective.	Fee schedule.	HCPCS defined units per quarter hour, hour, encounter, or day.	85% of the Medicare fee schedule The price for any supply listed in the fee schedule published by the Department shall include and is the lowest of: • Fees for initial measurements, fittings, adjustments, and related transportation costs. • Labor charges. • Delivery costs, fully prepaid by the provider, including any and all manufacturer's delivery charges with no additional	N/A	Last update was 1/1/2024 when new codes were added. No set update schedule.

[155] https://www.oregon.gov/oha/HSD/OHP/Policies/129-changes-010124.pdf; :
https://secure.sos.state.or.us/oard/viewSingleRule.action;JSESSIONID_OARD=UDjNTQMIsqXCUFSJvd_OtKbK_Xr6FNNoD2ekOUG-xu88UDz40DgV!1961848273?ruleVrsnRsn=308479 ,
https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=309878; https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=309923
[156] https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=ch7_MEDS.pdf&URI=Manuals/ch7_MEDS.pdf

MEDS – Medical Surgical Supplies						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				charges to be made for packing or shipping. • Travel to the client's home. • Technical assistance to the client to teach the client, or his or her family, the proper use and care of the supplies. • Information furnished by the provider to the client over the telephone.		
Maine, Massachusetts, New Jersey, New York, Oregon, Medicare	See MEDS-DME discussion.					

MEDS – Miscellaneous

MEDS – Miscellaneous						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[157]	Prospective.	Medicare fee schedule.	Procedure code (HCPCS/CPT) defined units per quarter hour, hour, encounter, or day.	85% of the Medicare fee schedule. . Each year, new procedure codes are developed to expand the code set to include new MEDS products or better describe products and are paid at 85% of the Medicare Fee Schedule at the time the code is added. .	N/A	Last update was 11/1/2021 for code additions. No set update schedule.
Maine, Massachusetts, New Jersey, New York, Medicare	See MEDS-DME discussion.					

MEDS – Enteral/Parenteral

MEDS – Enteral/Parenteral						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[158]	Prospective.	Medicare fee schedule.	HCPCS defined units per quarter hour, hour, encounter, or day.	• 85% of Medicare fee schedule. • No regular updates. Each year, new procedure codes are developed to expand the code set to include new MEDS products or better describe products and are paid at 85% of	N/A	• Last update was 1/1/2024 when a new code was added.

[157] https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=ch7_MEDS.pdf&URI=Manuals/ch7_MEDS.pdf; information provided to Myers and Stauffer by DSS January 2024.
[158] https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=ch7_MEDS.pdf; information provided to Myers and Stauffer by DSS January 2024.

MEDS – Enteral/Parenteral						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				the Medicare Fee Schedule at the time the code is added.		• No set update schedule.
Maine[159]	Prospective.	Fee schedule.	HCPCS.	Specialty modified low protein food reimbursement is invoice cost plus fifteen percent (15%):	N/A	No information published about updates.
Massachusetts[160]	Prospective.	Fee schedule.	HCPCS.	MA pays using an Adjusted Acquisition Cost (AAC) which includes the DME/Supplies/other items excluding any shipping, handling, sales tax and insurance costs. They do not pay above acquisition costs (all discounts must be documented). Certain items and services are paid at a higher rate than the AAC.	N/A	No information published about updates.
New Jersey[161]	See MEDs-DME discussion.					
New York[162]	See MEDs-DME discussion.					
Oregon[163]	See MEDs-DME discussion.					

[159] https://www.maine.gov/sos/cec/rules/10/144/ch101/c2s060.docx

[160] https://www.mass.gov/doc/101-cmr-322-rates-for-durable-medical-equipment-oxygen-and-respiratory-therapy-equipment/download

[161] New Jersey 4.19-B Page 7; https://www.nj.gov/dobi/division_insurance/medfees/Exhibit5_FinalEO2Version.pdf

[162] https://www.emedny.org/ProviderManuals/DME/PDFS/DME_Policy_Section.pdf

[163] https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=310065

MEDS – Prosthetic/Orthotic

MEDS – Prosthetic/Orthotic						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[164]	Prospective.	Fee schedule.	HCPCS.	85% of the Medicare fee schedule. The price for any device listed in the fee schedule includes: • Fees for initial fittings and adjustments and related subsequent adjustments • Labor charges • Delivery costs, fully prepaid by the provider, including any manufacturer's delivery charges, postage, packing and shipping. • All travel costs incurred by the provider associated with measurements, fittings, adjustments, or repairs. • Technical assistance to the client to teach the client, or his or her family or the designated representative the proper use and care of the equipment. • Fees for providing information to the client over the telephone.	A provider or client may request that an item be added to the fee schedule. The Department, at its discretion, may decide to add requested items during its regular revisions to the fee schedule, as published by the Department.	No set update schedule.

[164] https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=ch7_MEDS.pdf&URI=Manuals/ch7_MEDS.pdf

MEDS – Prosthetic/Orthotic						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				In addition, payment is made for customized orthotic or prosthetic device for a client who dies or is not otherwise eligible on the date of delivery providing the client was eligible on the date the prior authorization was given by the department; or the date the client ordered the device if the item does not require prior authorization.		
Maine, Massachusetts, New Jersey, New York, Oregon	See MEDs-DME discussion.					

Naturopath

Naturopath						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[165]	Prospective.	Negotiated.	Procedure code (HCPCS/CPT) defined units per quarter hour, hour,	90% of the CT physician fee schedule.	N/A	No set update schedule.

[165] https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=ch7_natureopath.pdf&URI=Manuals/ch7_natureopath.pdf; information provided to Myers and Stauffer by DSS January 2024.

Naturopath						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
			encounter, or day.			
Maine	See Physician and Outpatient Services discussion.					
New Jersey[166]	Does not cover services provided by naturopathic physicians.					
New York[167]	Does not cover services provided by naturopathic physicians.					
Oregon	See Physician and Outpatient Services discussion. Prospective.					
Medicare[168]	Does not cover services provided by naturopathic physicians.					

Nursing Facility

Nursing Facility						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[169]	Prospective.	• 2019 cost reports. • Case Mix-Resource utilization group (RUG) 48 grouper.	Per diem.	Cost components: • Direct (maximum of 135% of median cost). • Indirect (maximum of 115% of median cost). • Admin/general (maximum of 100% of median). • Property (fair rental). • Capital-related – fair rental. • Return on equity. Minimum occupancy = 90%.	• Quarterly case mix adjustments. • Legislative add-ons.	Rebasing no more frequently than every two years and no less than every four years.

[166] https://www.nj.gov/humanservices/dmahs/clients/medicaid/needs/
[167] https://naturopathic.org/page/ScopeforPatients
[168] https://www.medicarefaq.com/faqs/will-medicare-cover-naturopathy
[169] https://portal.ct.gov/DSS/Health-And-Home-Care/Medicaid-Nursing-Home-Reimbursement/Nursing-Home-Reimbursement-Acuity-Based-Methodology

Nursing Facility						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Maine[170]	Prospective.	• 2022 cost reports. • Cost based with limits. • Case Mix RUGS.	Per Diem.	Cost components: • Direct – Maximum is 110% of the median. • Routine - Maximum is 110% of the median. • Fixed - Cost Based with a minimum occupancy of 70%. Inflation for direct and routine costs from the end of the base year using the Historical CPI for Urban Wage and Clerical Workers. In February 2024, Maine published its proposal for reformed reimbursement, the objectives of which are to: • Prioritize direct care staff levels that are significantly higher than the State's minimum requirements and the federal proposed requirements, because higher staffing levels are related to quality of care and quality of life; • Provide an incentive to reduce contract (temporary) staffing, because high use of temporary staffing increases costs, reduces	• Direct Care rates are adjusted to cover at least 125% of the minimum wage annually. • Add-on to Support Essential Support Worker Wages at 125% of State Minimum.	Rebased every 2 years.

[170] https://www.maine.gov/dhhs/oms/providers/provider-bulletins/attention-nursing-facilities-and-residential-care-facilities-rate-letters-state-fiscal-year; https://www.maine.gov/dhhs/blog/maine-dhhs-proposes-framework-nursing-facility-rate-reform-2024-02-23

Nursing Facility						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				morale and creates barriers to quality improvement. • Encourage facilities to increase occupancy levels, which remain below pre-pandemic levels; and • Include a value-based payment that will tie a portion of payment to staffing levels and stability, clinical outcomes, resident satisfaction, and high Maine utilization. Nursing facility rate reform is scheduled to begin January 2025. Rate reform will reduce complexity and eliminate "cost settlement" for direct and routine costs, making budgets more predictable for both facilities and Maine. Currently, Maine pays nursing facilities interim rates for their costs throughout the year and reconciles any differences between those payments and allowable costs at the conclusion of the year.		
Massachusetts[171]	Prospective.	• 2019 Base Year. • Hybrid (price and cost).	Per Diem.	• Nursing Standard Payments (direct care costs) based on 2019 costs; effective 10/1/23, standard nursing payments are adjusted and paid for each PDPM nursing case mix category.	• Effective 10/1/2023, facilities may be eligible for a quality adjustment in	Rebasing frequency not specified, but rates are updated annually based

[171] https://www.mass.gov/doc/standard-payments-to-nursing-facilities-effective-october-1-2023-0/download

Nursing Facility						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
		• Case Mix-Patient-Driven Payment Model (PDPM) - Resident Specific Rates.		• Operating Cost Standard Payments - 2019 costs, statewide price. • Capital Payments - cost based with a cap of $50 per day. Occupancy adjustment of 90%. • Nursing and operating payments are increased from the 2019 base year by a cost adjustment factor of 21.94%. • Capital payments are increased from the 2019 base year by a cost adjustment factor of 7.55%.	the form of an increase or decrease applied to the facility's nursing standard rate at each PDPM nursing case mix category. • Quality adjustment is equal to the sum of the percent increase or decrease assessed for performance on 4 quality measures. • Add on for facilities with kosher kitchen and food service operations. • Pediatric nursing facility rates are adjusted upwards. • Other misc. add-ons: Ventilator, COVID,	on a cost adjustment factor.

Nursing Facility						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
					tracheostomy, homelessness, SUD, dialysis, behavioral indicators, bariatric and more.	
New Jersey[172]	Prospective.	• Hybrid (price and cost.) • Case Mix based on RUGs. • Separate rates based on groups: Group 1 – Proprietary and Voluntary, Group 2 – Governmental.	Per Diem.	Rate components: • Direct Care component- case mix and non-case mix; limited to 115% of the Medicaid day weighted median for Class 1 facilities, 105% of the Medicaid day weighted median for Class 2 facilities; adjusted for case mix quarterly. • Operating and Administrative Price—For Class 1 facilities, 100% of the day weighted median, for Class 2 facilities, 104.5 percent of the Class 1 NF operating and administrative price. • Facility specific fair rental value allowance. • Provider tax pass through per diem.	• Provider tax pass through. • The Quality Incentive Payment Program (QIPP) gives nursing facilities the opportunity to earn bonus payments if they achieve specific quality and performance goals that are essential to providing appropriate resident care. Each facility is eligible to earn an additional	• Every three years. • Adjusted for inflation in years with no rebasing. • For FRV calculations, each facility is adjusted on July 1 to make the facility one year older.

[172] https://www.nj.gov/humanservices/doas/resources/nursing/, Medicaid State Plan, Attachment 4.19B, TN23-0020.

Nursing Facility						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
					payments per resident per day on top of their normal rate for residents that are Medicaid members based on the number of quality benchmarks that the facility achieves.	
New York[173]	Prospective.	• Hybrid (price and cost) • Case Mix using RUGs. • 2007 Base Year	Per Diem.	Rate Components: • Direct Care Case Mix adjusted – Price Based, by region. • Indirect – Price Based by Region. • Non-Comparable Component which includes various ancillary and support services- Cost Based. • Capital Component – Cost Based.	• The New York State Nursing Home Quality Initiative (NHQI) is an annual quality and performance evaluation project to improve the quality of care for residents in Medicaid-certified nursing	• 7.5% rate increase to the operating component of rates effective October 2024. • State froze case-mix rates pending implement

[173] https://www.health.ny.gov/facilities/long_term_care/reimbursement/nhr/2024/docs/2024-07-16_dal.pdf; https://www.health.ny.gov/health_care/medicaid/redesign/nursing_home_quality_initiative.htm; State Plan 4.19-D; https://regs.health.ny.gov/content/section-86-238-nursing-home-incentive-payment

Nursing Facility						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
					facilities across New York State. • Current NHQI is based on the previous calendar year´s performance. Nursing homes are awarded points for quality and performance measures in the components of Quality, Compliance, and Efficiency. Specific deficiencies cited during the health inspection survey process are also incorporated into the results. The points for all measures are then summed to create an overall score for each facility.	ation of PDPM.

Nursing Facility						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Oregon[174]	Prospective.	• Hybrid • Allowable Costs	Per Diem.	A standard, statewide flat rate which bears a fixed relationship to reported allowable costs; and is set at the 62nd percentile of allowable costs (both direct and indirect).	• Complex medical needs add-on, 40% of the base rate • Ventilator Assisted program rate, 235% of the base rate. • Pediatric Rate. • Bariatric Rate. • Outlier payments may be made when a client has a combination of extraordinary medical, behavioral, and or social needs and existing payment categories do not address these.	Annual.
Medicare	Prospective.	• 1995 Base year.	Per diem.	Skilled nursing facility (SNF) PPS.	Patient characteristics, geographic wage	Annual using a SNF market basket index.

[174] State Plan, Attachment 4.19-D, Part 1, Page 1, TN 20-0016

Nursing Facility						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
		• Cost reports, patient acuity/resource intensity. • PDPM case mix classification system.			variation (hospital wage index), quality (SNF VBP).	

Optician/Eyeglasses

Optician/Eyeglasses						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[175]	Prospective.	Fee schedule.	CPT/HCPCS.	Effective 7/1/08, an increase of 34% in the fee for vision hardware for Fee-for-Service was implemented. For rate setting purposes, it was assumed that the rate increase started on 1/1/08 and was evenly applied through calendar 2008 for MCO.	N/A	No set update schedule.
Maine[176]	Prospective.	Medicare fee schedule.	CPT/HCPCS.	• 53% of Medicare for professional services. • Vision service providers must use Maine's designated Vision Care Volume Purchase Contractor as the sole supplier of all eyeglasses	N/A	Updated based on competitive bid RFP; professional services updated annually.

[175] https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=ch7_vision.pdf&URI=Manuals/ch7_vision.pdf ; information provided to Myers and Stauffer January 2024.
[176]https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.maine.gov%2Fsos%2Fcec%2Frules%2F10%2F144%2Fch101%2Fc2s075.docx&wdOrigin=BROWSELINKhttps://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.maine.gov%2Fsos%2Fcec%2Frules%2F10%2F144%2Fch101%2Fc2s075.docx&wdOrigin=BROWSELINK

Optician/Eyeglasses						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				for Maine members with no Medicare or other third party coverage. This includes lenses, frames, associated parts and cases.		
Massachusetts[177]	Prospective.	Fee schedule.	CPT/HCPCS.	• Services performed by ophthalmologists are paid based on physician fee schedule. • Methodology for determining fees for eyeglass lens, frames, contact lenses, low vision aids, prosthetic eyes, intraocular lens.	N/A	No information published about updates.
New York[178]	Prospective.	Fee schedule.	CPT/HCPCS.	• Fee schedule includes optometrists, opticians, optical establishments and ocularists. • Methodology for determining fees is not published.	N/A	No information published about updates.
Oregon[179]	Prospective.	Negotiated and fee schedule.	CPT/HCPCS.	• Division contracts with an optical laboratory to provide vision materials and supplies, also frames. Providers needing materials and supplies must order directly from the contractor. • All other items are paid based on the fee schedule.	N/A	No information published about updates.

[177] https://www.mass.gov/doc/101-cmr-315-rates-for-vision-care-services-and-ophthalmic-materials/download
[178] https://www.emedny.org/ProviderManuals/VisionCare/PDFS/VisionCare_Policy_Guidelines.pdf
[179] https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1727

Optician/Eyeglasses						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
New Jersey[180]	Prospective.	Fee schedule.	CPT/HCPCS.	• Fee schedule includes ophthalmologists, optometrists, independent clinics, hospitals, opticians, ocularists. • Methodology for determining fees is not published.	N/A	No information published about updates.
Medicare [181]	Prospective.	Fee schedule.	See Medicare MEDS-DME discussion.			

Psychologist Services

Psychologist Services						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[182]	Prospective fee schedule.	2007 Medicare RBRVS.	Procedure code (HCPCS/CPT).	Rate is 100% of the CT rate from the physician fee schedule. That rate is based on a percentage of the MPFS. When first implemented in 2008, the rates were determined as 57.5% of the 2007 fee schedule.	Supplemental payment program for Connecticut Children's Medical Center Physician Group to pay up to 100% of the	No regular updates made. Newly added codes are paid based on 57.5% of the Medicare fee schedule at

[180] https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.nj.gov%2Fhumanservices%2Fproviders%2Frulefees%2Fregs%2FNJAC%252010_62%2520Vision%2520Care%2520Services%2520Manual.doc&wdOrigin=BROWSELINK

[181] https://www.anthem.com/medicare/learn-about-medicare/does-medicare-cover-vision#:~:text=Original%20Medicare%E2%80%A1%20Parts%20A,surgeries%2C%20such%20as%20cataract%20removal; https://www.medicare.gov/media/publication/11045-medicare-coverage-of-dme-and-other-devices.pdf; Medicare Parts A and B do not cover vision care, except in certain circumstances, such as coverage of eye exams if the beneficiary is a higher risk for eye complications such as glaucoma. Medicare will not cover routine eye exams, glasses, or contacts. Medicare will cover one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens.

[182] Documentation provided by DSS to Myers and Stauffer.

Psychologist Services						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				The HUSKY Health Primary Care Fee Schedule increases rates for specific certain primary care codes routinely used by eligible primary care providers. Marriage and family therapists and counselors are covered providers (effective 10/1/2022).	Medicare fee schedule.	the time the new code is added.
Maine, Massachusetts, New Jersey, New York, Oregon	See Physician and Outpatient Services.					
Medicare[183], [184]	Prospective fee schedule.	RBRVS.	Procedure code (HCPCS/CPT).	Medicare includes psychiatrists (operating within their scope of services) to be physicians and pays 100% of the physician rate for covered services. Fee schedule developed by multiplying the relative value of a code, times a CF (i.e., RVU * CF = RBRVS rates):	Different rates for facility, non-facility providers Physicians who provide professional services in a Primary Care or Mental Health	Annual.

[183] https://www.ama-assn.org/about/rvs-update-committee-ruc/rbrvs-overview#:~:text=The%20RBRVS%20is%20based%20on,avenue%20to%20continuously%20improve%20it
[184] https://www.apaservices.org/practice/reimbursement/government/2024-medicare-medicaid-fee-schedule-proposed-rule

Psychologist Services						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				• RVUs have three components: Physician Work, Practice Expense, and Professional Liability Insurance. • Fee schedule is adjusted to reflect the variation in practice costs across the country. A Geographic Practice Cost Index is established for each locale.	Professional Shortage Area are eligible for a 10% bonus payment.	

Physician and Outpatient Services/HUSKY Primary Care/Psychiatrists

Physician and Outpatient Services /HUSKY Primary Care/Psychiatrist						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut	Prospective fee schedule.	2007 Medicare RBRVS (see Medicare below) based on HCPCS/CPT. Physician Office and Outpatient Fee schedule.	Defined by procedure code (HCPCS/CPT).	The rate is based on a percentage of the Medicare Physician Fee Schedule (MPFS). When first implemented in 2008, the rates were determined as 57.5% of the 2007 fee schedule.[185] Obstetrician fee schedule determined as 145% of the 2007 fee schedule.	90% of Medicaid fee schedule for: • Nurse practitioners. • Physician assistants. • Advanced practice registered nurse (APRNs).	No regular updates made. Relative values are not updated when the Centers for Medicare & Medicaid Services (CMS)

[185] Documentation provided by DSS to Myers and Stauffer.

Physician and Outpatient Services /HUSKY Primary Care/Psychiatrist						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
		HUSKY Health Care Primary Fee Schedule. Psychiatric Services is its own fee schedule determined through the Medicare RBRVS.		Psychiatrists paid at 100% of the 2007 fee schedule. The HUSKY Health Primary Care Fee Schedule increases rates for specific certain primary care codes routinely used by eligible primary care providers. Payment is lowest of the following: • Provider's usual and customary charges. • The lowest MCR Rate. • Applicable fee schedule. • Amount billed by provider.[186]	Nurse midwives fee schedule changed to 100% of Medicaid fee schedule effective 7/1/2021. Physician administration of drugs paid at 100% of the fee schedule (HCPCS J-codes, Q-codes, S-codes and CPT 99070). There are fee differentials for certain services when provided in a facility versus an office setting. Supplemental payment program for CT Children's Medical Center Physician Group to pay up to 100% of the Medicare fee schedule.	updates the RBRVS. Newly added codes are paid based on 57.5% of the Medicare fee schedule at the time the new code is added.[187]

[186] This is a requirement for all the states reviewed here, and the entry is not repeated.
[187] Source: Discussions with CT DSS staff and Myers and Stauffer.

Physician and Outpatient Services /HUSKY Primary Care/Psychiatrist						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Maine	Prospective fee schedule.	Current Medicare RBRVS. (See Medicare below).	Defined by procedure code (HCPCS/CPT).	Benchmarks rates to the current Medicare rate, currently 72.4% of the Medicare rate. Reimbursement for enhanced primary care services are 100% of the Medicare rate.[188]	There are fee differentials for certain services when provided in a facility versus an office setting.	7/1/2022.[189]
Massachusetts[190]	Prospective fee schedule.	Medicare RBRVS (see Medicare below).	Defined by procedure code (HCPCS/CPT).	N/A	85% of fee schedule for certified nurse practitioners, certified nurse midwives, psychiatric clinical nurse specialists, clinical nurse specialists, physician assistants, registered nurses, tobacco cessation counselors. There are fee differentials for certain services when provided in a facility versus an office setting.	N/A

[188] https://www.maine.gov/dhhs/oms/about-us/projects-initiatives/mainecare-rate-system-reform
[189] https://www.maine.gov/dhhs/oms/providers/provider-bulletins/mainecare-cost-living-adjustments-2022-06-03#:~:text=The%20COLA%20will%20be%20equal,as%20of%20January%201%2C%202022
[190] https://www.mass.gov/doc/101-cmr-317-rates-for-medicine-services/download

Physician and Outpatient Services /HUSKY Primary Care/Psychiatrist						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
					Primary care clinicians (PCCs) receive an enhanced rate for certain types of primary and preventive care visits provided to PCC Plan members enrolled with the PCC on the date of service. As of April 2023, primary care providers participating in the Accountable Care Organization (ACO) supported by the State's 1115 demonstration receive sub-capitation payments instead of fee-for-service reimbursement.[191]	
New Jersey[192]	Prospective fee schedule.	Medicare RBRVS (see Medicare below).	Defined by procedure code (HCPCS/CPT).	MPFS in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be	Fee schedule differentiates rates based on whether a	9/1/2023 effective for

[191] https://www.milbank.org/news/how-massachusetts-medicaid-is-paying-for-primary-care-teams-to-take-care-of-people-not-doctors-to-deliver-services/
[192] https://www.nj.gov/humanservices/dmahs/info/state_plan/Attachment4_Payments_and_Rates.pdf, nj.gov/humanservices/providers/rulefees/regs/NJAC%2010_54%20Physician%20Services.pdf

Physician and Outpatient Services /HUSKY Primary Care/Psychiatrist						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				applicable in those years using the calendar year 2009 MPFS conversion factor (CF). If there is no applicable rate established by Medicare, the State uses the rate specified in a fee schedule established and announced by CMS. Same methodology applies for APRNs.[193] Physician fee schedule includes psychiatrists.	physician is a specialist or non-specialist. No site of service adjustment. Nurse midwives and licensed midwives paid 100% of physician specialist fee.[194] Physicians are eligible to receive supplemental payments if affiliated with medical schools. Payments are intended to increase payment levels to average commercial rates.	Date of Service 7/1/2023. Rates for enhanced physician services updated annually and paid based on the following percentages: • 52% of the current published Medicare rate for primary care • 70% of the current published Medicare rate for preventive and screening services • 50% of the published

[193] https://nj.gov/humanservices/providers/rulefees/regs/NJAC%2010_58A%20Advanced%20Practice%20Nurse%20Services.pdf
[194] https://www.nj.gov/humanservices/dmahs/info/state_plan/Attachment4_Payments_and_Rates.pdf, p. 16 Attachment 4.19 – B.

Physician and Outpatient Services /HUSKY Primary Care/Psychiatrist						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
						Medicare rate for postpartum services[195]
New York[196]	Prospective fee schedule.	Medicare RBRVS (see Medicare below).	Defined by procedure code (HCPCS/CPT).	Benchmarks the physician fee schedule to Medicare: 60% of the Medicare fee schedule for office-based services and 50% of the Medicare fee schedule for facility-based services. For the 2023-2024 budget, rates are benchmarked to 80% of current Medicare reimbursement rates for non-facility services. (Includes Medicine, Drug, Surgery, and Radiology).	Effective for the 2023-2024 year, NPs will receive 95% of the new Medicaid fee schedule. There are fee differentials for certain services when provided in a facility versus an office setting. Physicians enrolled in the following programs are entitled to enhanced fees: • Preferred Physicians and Children Program • Medicaid Obstetrical and	New fees implemented 10/1/2023, no schedule listed for future updates.

[195] Attachment 4.19 – B, Medicaid State Plan, page 36b.
[196] https://health.ny.gov/health_care/medicaid/program/update/2023/no13_2023-08.htm

Physician and Outpatient Services /HUSKY Primary Care/Psychiatrist						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
					Maternal Services Program • HIV Enhanced Fees for Physicians Program	
Oregon[197]	Prospective fee schedule.	Medicare RBRVS (see Medicare below).	Defined by procedure code (HCPCS/CPT).	Relative value unit (RVU) weights are based on Medicare's 2023 non-facility or facility RVU weights, multiplied by the following base rates: • Labor and delivery: $40.79 • Neonatal and pediatric intensive care: $38.76 • Primary care: $27.82 (evaluation and management [E/M], immunization administration, health and behavior assessment /intervention) • All other codes: $25.48[198]	Fee schedule for physician assistants, other practitioners (NPs and Midwives), is not reduced.	No information published about updates.
Medicare[199]	Prospective fee schedule.	Resource-Based Relative Value Scale (RBRVS). Includes are professionals,	Defined by procedure code (HCPCS/CPT); some packaging of minor services.	Fee schedule developed by multiplying the relative value of a code times a CF (i.e., RVU * CF = RBRVS rates): • RVUs have three components: Physician Work, Practice	Pays services furnished by nurse practitioners and physician assistants at 85% of the allowed amount for	Fee schedule is updated annually by CMS, with new rates going into effect

[197] Oregon Medicaid State Plan, Attachment 4.19-B, page 1.
[198] https://www.oregon.gov/oha/HSD/OHP/Tools/ffs-medical-dental-rates.pdf
[199] https://www.ama-assn.org/about/rvs-update-committee-ruc/rbrvs-overview#:~:text=The%20RBRVS%20is%20based%20on,avenue%20to%20continuously%20improve%20it

Physician and Outpatient Services /HUSKY Primary Care/Psychiatrist						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
		including psychiatrists.		Expense, and Professional Liability Insurance • Fee schedule is adjusted to reflect the variation in practice costs across the country. A Geographic Practice Cost Index is established for each locale.	physician services; pays clinical social workers at 75% of the allowed amount. There are fee differentials for certain services when provided in a facility versus an office setting. Physicians who provide professional services in a Primary Care or Mental Health Professional Shortage Area are eligible for a 10-percent bonus payment.	January 1 of each year.

Physician – Anesthesiology

Physician Anesthesiology						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[200]	Prospective fee schedule.	2007 Medicare RBRVS (see Medicare below.) Physician Anesthesiology Fee schedule.	Defined by procedure code (HCPCS/ CPT).	Rate formula is (Units/15+ relative value) * CF [currently $14][201]	CRNA rates are 100% of the Physician Anesthesiology Fee Schedule.	No set update schedule.
Maine[202]	Prospective fee schedule.	Medicare RBVS. Physician Anesthesiology Fee schedule.	Defined by procedure code (HCPCS/ CPT).	The fee schedule is based on: • 72.4% of the current year's Medicare rate for Maine, including appropriate Medicare fee adjustments for place of service and modifiers in effect at that time; or • If no Medicare rate available, the research of other State Medicaid agencies that cover the relevant service/code. The Department will base its rate on the average cost of the relevant services/codes from those other agencies. • If the above two options are not available, research of other State Medicaid agencies that cover the	CRNA fee schedule is 75% of amount allowed for physician services.[203]	Last updated 7/1/2022.

[200] Documentation provided by DSS to Myers and Stauffer.
[201] https://www.ctdssmap.com/CTPortal/Provider/Provider-Fee-Schedule-Download
[202] *Maine Care Benefits Manual*, Chapter II, Section 90, pp. 40-41.
[203] https://casetext.com/regulation/maine-administrative-code/department-10-department-of-health-and-human-services/division-144-department-of-health-and-human-services-general/chapter-101-mainecare-benefits-manual-formerly-maine-medical-assistance-manual/chapter-ii-specific-policies-by-service/section-144-101-ii-90-physician-services/subsection-144-101-ii-9004-covered-services

Physician Anesthesiology						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				relevant service/code. The Department will base its rate on the average cost of the relevant services/codes from those other agencies.		
Massachusetts[204]	Prospective fee schedule.	Medicare RBRVS.	Defined by procedure code (HCPCS/ CPT).	(Base anesthesia units * $19.90) + (Per minute anesthesia units * $1.33) CF = $19.90.	Fee schedule for personally performed anesthesia services by a CRNA, is 100% of the total anesthesia fee; Fee schedule for payment for the CRNA's services performed with medical direction of an anesthesiologist is 50% of the total anesthesia fee. Rates adjusted based on site of service. Supplemental payments are available for certain providers,	N/A

[204] https://www.mass.gov/doc/101-cmr-316-rates-for-surgery-and-anesthesia-services/download

Physician Anesthesiology						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
					see *Physician Services/psychiatrist/HUSKY Health Care Office and Outpatient Services.*	
New Jersey[205]	Prospective fee Schedule.	Medicare RBRVS.	Defined by procedure code (HCPCS/ CPT).	Anesthesiologists are paid based on total of anesthesia base units + anesthesia time units [Base Units + Anesthesia Time (based on 15-minute increments i.e. 1 unit is equivalent to 15 minutes)] x Either Specialist Per Unit ($9.30) OR Non-Specialist Per Unit ($8.10).	APRN fee schedule is 100% of physician fee schedule. Fee schedule differentiates rates based on whether a physician is a specialist or non-specialist. Physicians are eligible to receive supplemental payments if affiliated with medical schools. Payments are intended to increase payment levels to average	Last update on the master Medicaid Fee for Service schedule was 10/1/2023.

[205] www.nj.gov/humanservices/providers/rulefees/regs/NJAC%2010_54%20Physician%20Services.pdf

Physician Anesthesiology						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
					commercial rates.[206]	
New York	Prospective fee schedule.[207]	Medicare RBRVS.	Defined by procedure code (HCPCS/ CPT).	(Base anesthesia units * $10.00) + (Anesthesia minutes / 15 * $10.00) CF = $10.00 CRNAs cannot bill separately.[208]	Providers enrolled in the following programs receive enhanced fees: • Preferred Physicians and Children Program. • Medicaid Obstetrical and Maternal Services Program. • HIV enhanced Fees for Physicians Program.	N/A
Oregon[209]	Prospective fee schedule.	Medicare RBRVS.	Defined by procedure code (HCPCS/ CPT).	(Base anesthesia units * $20.78) + ((Billed anesthesia minutes / 15) * $20.78) CF = $20.78.	N/A	N/A

[206] https://www.nj.gov/humanservices/dmahs/info/state_plan/Attachment4_Payments_and_Rates.pdf, p.4 of Supplement 1 to 4.19 b
[207] https://www.emedny.org/providermanuals/physician/PDFS/Physician_Procedure_Codes_Sect6.pdf
[208] https://www.health.ny.gov/health_care/medicaid/program/update/2010/2010-11.htm#:~:text=Likewise%2C%20Medicaid%20does%20not%20recognize,anesthesiologists%20for%20supervision%20of%20CRNAs
[209] https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=286416

Physician Anesthesiology						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Medicare	Prospective fee schedule.	RBRVS. Fee schedule for Anesthesia is different than for other medical and surgical services. The fee schedule is based on two parts: Number of "base units," which are assigned to anesthesia CPT codes by CMS The time the patient was under anesthesia. Both parts of the rate are multiplied by an anesthesia CF, updated annually and specific to the locality where the anesthesia service is rendered.	Defined by procedure code (HCPCS/ CPT).	[(Base Units) + (Anesthesia Time / 15 or Time Units)] * CF = Anesthesia Fee Amount[210] The national anesthesia CF is $21.1249	Fee schedule for CRNAs is 80% of the Medicare allowable amount (if non-medically directed). If the CRNA is medically directed, the fee schedule is 50% of the allowable charge. Deductible and coinsurance apply.[211] Different rates for facility, non-facility providers.	Fee schedule is updated annually by CMS, with new rates going into effect January 1 of each year.

[210] https://www.palmettogba.com/palmetto/jmb.nsf/DIDC/BE5QST1651~Specialties~Anesthesia%20and%20Pain%20Management
[211] https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/r1870a3.pdf

Physician – Radiology

Physician – Radiology						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut	Prospective fee schedule.	Medicare RBRVS.	Defined by procedure code (HCPCS/CPT).	The rate is based on a percentage of the MPFS. When first implemented in 2008, the rates were determined as 57.5% of the 2007 fee schedule.[212]	OBS radiologists paid at 110% of the fee schedule.	No regular updates made. Newly added codes are paid based on 57.5% of the Medicare fee schedule at the time the new code is added.
Maine[213]	Prospective fee schedule	Medicare RBRVS.	Defined by procedure code (HCPCS/CPT).	Benchmarks rates to the current Medicare rate, currently 72.4% of the Medicare rate. Reimbursement for enhanced primary care services are 100% of the Medicare rate.[214]	There are fee differentials for certain services when provided in a facility versus an office setting.	7/1/2022.
Massachusetts[215]	Prospective fee schedule.	Medicare RBRVS.	Defined by procedure code (HCPCS/CPT).	N/A	85% of fee schedule for: • Certified nurse practitioners. • Physician assistants.	N/A

[212] Documentation provided by DSS to Myers and Stauffer.
[213] *Maine Care Benefits Manual*, Chapter II, Section 90, pp. 40-41.
[214] https://www.maine.gov/dhhs/oms/about-us/projects-initiatives/mainecare-rate-system-reform
[215] https://www.mass.gov/doc/101-cmr-317-rates-for-medicine-services/download

Physician – Radiology						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
					There are fee differentials for certain services when provided in a facility versus an office setting. PCCs receive an enhanced rate for certain types of primary and preventive care visits provided to PCC Plan members enrolled with the PCC on the date of service.	
New Jersey[216]	Prospective fee schedule.	Medicare RBRVS.	Defined by procedure code (HCPCS/CPT).	MPFS in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 MPFS CF. If there is no applicable rate established by Medicare, the State uses the rate specified in a fee schedule established and announced by CMS.	Fee schedule differentiates rates based on whether a physician is a specialist or non-specialist. No site of service adjustment. Fee schedule differentiates rates based on whether a physician is a	9/1/2023 effective for DOS 7/1/2023. Rates for enhanced physician services are updated annually and paid based on

[216] www.nj.gov/humanservices/providers/rulefees/regs/NJAC%2010_54%20Physician%20Services.pdf

Physician – Radiology						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
					specialist or non-specialist.	the following percentages: • 52% of the current published Medicare rate for primary care • 70% of the current published Medicare rate for preventive and screening services • 50% of the published Medicare rate for postpartum services.[217]
New York[218]	Prospective fee schedule.	Medicare RBRVS.	Defined by procedure code (HCPCS/CPT).	Benchmarks the physician fee schedule to Medicare: 60% of the Medicare fee schedule for office-based services and 50% of the	There are fee differentials for certain services when provided in a	New fees implemented 10/1/2023, no schedule listed

[217] Attachment 4.19 – B, Medicaid State Plan, page 36b.
[218] https://health.ny.gov/health_care/medicaid/program/update/2023/no13_2023-08.htm

Physician – Radiology						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				Medicare fee schedule for facility-based services. For the 2023-2024 budget, rates are benchmarked to 80% of current Medicare reimbursement rates for non-facility services. .	facility versus an office setting. Physicians enrolled in the following programs are entitled to enhanced fees: • Preferred Physicians and Children Program. • Medicaid Obstetrical and Maternal Services Program • HIV Enhanced Fees for Physicians Program.	for future updates.
Oregon[219]	Prospective fee schedule.	Medicare RBRVS.-	Defined by procedure code (HCPCS/CPT).	RVU weights are based on Medicare's 2023 non facility or facility RVU weights, multiplied by the following base rates: • Labor and delivery: $40.79 • Neonatal and pediatric intensive care: $38.76	Fee schedule for physician assistants, other practitioners (NPs and midwives), is not reduced.	N/A

[219] Oregon Medicaid State Plan, Attachment 4.19-B.

Physician – Radiology						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				• Primary care: $27.82 (E/M, immunization administration, health and behavior assessment/intervention) • All other codes: $25.48[220]		
Medicare[221]	Prospective fee schedule.	RBRVS.	Defined by procedure code (HCPCS/CPT); some packaging of minor services.	Fee schedule developed by multiplying the relative value of a code times a CF (i.e., RVU * CF = RBRVS rates): • RVUs have three components: Physician Work, Practice Expense, and Professional Liability Insurance • Fee schedule is adjusted to reflect the variation in practice costs across the country. A Geographic Practice Cost Index is established for each locale.	Nurse practitioners and physician assistants paid 85% of the allowed amount. Different rates for facility, non-facility providers Physicians who provide professional services in a Primary Care or Mental Health Professional Shortage Area are eligible for a 10% bonus payment.	Fee schedule is updated annually by CMS, with new rates going into effect January 1 of each year.

[220] https://www.oregon.gov/oha/HSD/OHP/Tools/ffs-medical-dental-rates.pdf
[221] https://www.ama-assn.org/about/rvs-update-committee-ruc/rbrvs-overview#:~:text=The%20RBRVS%20is%20based%20on,avenue%20to%20continuously%20improve%20it

Physician – Surgery

Physician – Surgery						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[222]	Prospective fee schedule.	2007 Medicare RBRVS. Physician Surgical Fee Schedule.	Defined by procedure code (HCPCS/CPT).	The rate is based on a percentage of the MPFS. When first implemented in 2008, the rates were determined as 57.5% of the 2007 fee schedule. Obstetrician fee schedule determined as 145% of the 2007 fee schedule. The HUSKY Health Primary Care Fee Schedule increases rates for specific certain primary care codes routinely used by eligible primary care providers.	90% of Medicaid fee schedule for: • Nurse practitioners • Physician assistants • APRNs There are fee differentials for certain services when provided in a facility versus an office setting. Supplemental payment program for CT Children's Medical Center Physician Group to pay up to 100% of the Medicare fee schedule.	No regular updates made. Newly added codes are paid based on 57.5% of the Medicare fee schedule at the time the new code is added.

[222] Documentation provided by DSS to Myers and Stauffer.

Physician – Surgery						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Maine[223]	Prospective fee schedule.	Current Medicare RBRVS.	Defined by procedure code (HCPCS/CPT).	Benchmarks rates to the current Medicare rate, currently 72.4% of the Medicare rate.	Multiple surgeries: 50% of fee schedule. Assistance at Surgery: 20% of fee schedule. There are fee differentials for certain services when provided in a facility versus an office setting.	7/1/2022.
Massachusetts[224]	Prospective fee schedule.	Current Medicare RBRVS. Surgery and anesthesia services.	Defined by procedure code (HCPCS/CPT).	Information regarding base year implementation is not published.		No regular updates made.
New Jersey[225]	Prospective fee schedule.	Medicare RBRVS.	Defined by procedure code (HCPCS/CPT).	MPFS in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 MPFS CF. If there is no applicable rate established by	Fee schedule differentiates rates based on whether a physician is a specialist or non-specialist.	Last update on the master Medicaid Fee for Service schedule was 9/1/2023

[223] https://www.maine.gov/dhhs/oms/providers/provider-bulletins/mainecare-cost-living-adjustments-2022-06-03#:~:text=The%20COLA%20will%20be%20equal,as%20of%20January%201%2C%202022
[224] https://www.mass.gov/doc/101-cmr-317-rates-for-medicine-services/download
[225] www.nj.gov/humanservices/providers/rulefees/regs/NJAC%2010_54%20Physician%20Services.pdf

Physician – Surgery						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				Medicare, the State uses the rate specified in a fee schedule established and announced by CMS. Same methodology applies for APRNs.[226]	No site of service adjustment. Nurse midwives and licensed midwives paid 100% of physician specialist fee.[227] Physicians are eligible to receive supplemental payments if affiliated with medical schools. Payments are intended to increase payment levels to average commercial rates.	effective for DOS 7/1/2023. Rates for enhanced physician services are updated annually and paid 52% of the Medicare rate for primary care; 70% of the rate for preventive and screening services, and 50% of the rate for postpartum services.[228]
New York[229]	Prospective fee schedule.	Medicare RBRVS (see Medicare below).	Defined by procedure code (HCPCS/CPT).	Benchmarks the physician fee schedule to Medicare: 60% of the Medicare fee schedule for office-based services and 50% of the	Effective for the 2023-2024 year, NPs will receive 95% of the new	New fees implemented 10/1/2023, no schedule listed

[226] https://nj.gov/humanservices/providers/rulefees/regs/NJAC%2010_58A%20Advanced%20Practice%20Nurse%20Services.pdf
[227] https://www.nj.gov/humanservices/dmahs/info/state_plan/Attachment4_Payments_and_Rates.pdf, p. 16 Attachment 4.19 – B.
[228] Attachment 4.19 – B, Medicaid State Plan, page 36b.
[229] https://health.ny.gov/health_care/medicaid/program/update/2023/no13_2023-08.htm

Physician – Surgery						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				Medicare fee schedule for facility-based services. For the 2023-2024 budget, rates are benchmarked to 80% of current Medicare reimbursement rates for non-facility services. (Includes Medicine, Drug, Surgery, and Radiology).	Medicaid fee schedule. There are fee differentials for certain services when provided in a facility versus an office setting. Physicians enrolled in the following programs are entitled to enhanced fees: • Preferred Physicians and Children Program • Medicaid Obstetrical and Maternal Services Program • HIV Enhanced Fees for Physicians Program	for future updates.

Physician – Surgery						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Oregon[230]	Prospective fee schedule.	Medicare RBRVS (see Medicare below). .	Defined by procedure code (HCPCS/CPT).	RVU weights are based on Medicare's 2023 non facility or facility RVU weights, multiplied by the following base rates: • Labor and delivery: $40.79 • Neonatal and pediatric intensive care: $38.76 • Primary care: $27.82 (E/M, immunization administration, health and behavior assessment/intervention) • All other codes: $25.48[231]	Fee schedule for physician assistants, other practitioners (NPs and Midwives), is not reduced.	No information published about updates.
Medicare[232]	Prospective fee schedule.	RBRVS.	Defined by procedure code (HCPCS/CPT).	Fee schedule developed by multiplying the relative value of a code times a CF (i.e., RVU * CF = RBRVS rates): • RVUs have three components: Physician Work, Practice Expense, and Professional Liability Insurance • Fee schedule is adjusted to reflect the variation in practice costs across the country. A Geographic Practice Cost Index is established for each locale. • Anesthesia has its own CF.	Unless their services are billed "incident to" a physician's service, the RBRVS-based fee schedule: a) pays services furnished by nurse practitioners and physician assistants at 85% of the allowed amount for physician services; b) pays clinical social workers at	Fee schedule is updated annually by CMS, with new rates going into effect January 1 of each year.

[230] Oregon Medicaid State Plan, Attachment 4.19-B.
[231] https://www.oregon.gov/oha/HSD/OHP/Tools/ffs-medical-dental-rates.pdf
[232] https://www.ama-assn.org/about/rvs-update-committee-ruc/rbrvs-overview#:~:text=The%20RBRVS%20is%20based%20on,avenue%20to%20continuously%20improve%20it

Physician – Surgery						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
					75% of the allowed amount. Different rates for facility, non-facility providers. Physicians who provide professional services in a Primary Care or Mental Health Professional Shortage Area are eligible for a 10-percent bonus payment.	

Private Psychiatric Residential Treatment Facilities (PRTF) (Private)

PRTF						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
Connecticut[233]	Prospective.	Negotiated based on cost information submitted on the Annual PRTF Cost Report.	Per diem.	An inclusive payment for all services that are required to be provided by the facility as a condition for participation as a PRTF.	N/A	As needed. Most recent update to the reimbursement rate was effective 1/1/23 to account for higher costs related to adding director of nursing staffing. To receive this rate, each PRTF must maintain this director of nursing staffing, in addition to all other applicable requirements, including the quality standards set forth in the Medicaid State Plan.
Maine[234]	Prospective.	• Routine and fixed costs.	Per Diem.	• Statewide per diem rate for medical, clinical and direct care	When a facility is found not to have	Proposed rate proposal

[233] https://portal.ct.gov/dss/health-and-home-care/medicaid-state-plan-amendments/archive-2023, SPA 23-E.

[234] https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.maine.gov%2Fsos%2Fcec%2Frules%2F10%2F144%2Fch101%2Fc3s107.docx&wdOrigin=BROWSELINK; https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/2023.06.15%20PRTF%20DRAFT%20Rate%20Public%20Forum.pdf

PRTF						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
		facility rate based on annual cost reports. • Medical, clinical, and direct care costs are not cost settled.		costs (direct care services), which is not cost-settled. Includes services provided by the medical, clinical, and direct care services staff; includes salaries, wages, and benefits. The per diem rate is $485.72 (effective 10/2018). • Facility-specific rate for routine and fixed costs (room and board costs), based on annual cost report.	provided the quality of service or level of care required, reimbursement will be made on ninety percent (90%) of the provider's per diem rate, unless otherwise specified.	completed Fall 2023, with rule adoption scheduled for Spring 2024. Direct care rate was to be increased to $606.83; this rule has not yet been implemented.
Massachusetts [235]	Prospective	Annual Uniform Financial Statements and Independent Audit Reports.	Per diem	PRTF-like services are a subset within the Intensive Residential Treatment Program.[236] Methodology not published.	Add-on rates available in response to unusual and unforeseen circumstances.	Annual.
New Jersey[237]	Prospective.	Rates are based on reasonable costs, as defined in the Department of	HCPCS codes: (Y9947-9950).	The Department of Youth and Family Services, Medicaid, and the Department of Mental Health contract for services based on a negotiated rate.	N/A	No information published about updates.

[235] Massachusetts refers to these services as Youth Intermediate-Term Stabilization Services; https://www.mass.gov/doc/101-cmr-413-payments-for-youth-intermediate-term-stabilization-services/download.
[236] Rates for Youth Intermediate Term Stabilization Services, Intensive Treatment Program Enhanced RTC and non-ERTP programs provided the basis for comparison in the rate study.
[237] https://www.nj.gov/dcf/documents/contract/manuals/CRM7.pdf,
https://www.nj.gov/humanservices/providers/rulefees/regs/NJAC%2010_75%20Psychiatric%20Residential%20Treatment%20Facility%20Services%20for%20Individuals%20Under%20Age%2021.pdf

PRTF						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
		Human Services' Contract Reimbursement Manual and the Contract Policy and Information Manual.		For non-state-owned providers, price analysis is the evaluation of data without analysis of the separate cost components and profit which may assist in arriving at prices to be paid and cost to be reimbursed.		
New York[238]	Prospective, provider-specific rates.	Cost reports from two years prior to the rate year.	Per Diem.	Prospective rates, based upon actual costs and patient days as reported on cost reports for the fiscal year two years prior to the rate year. Actual patient days are subject to a maximum utilization of 96 percent and a minimum utilization of 90 percent. Two components of cost: operating and capital. • Allowable per diem operating costs are limited to the lesser of the reported costs or the amount derived from the number of clinical staff approved by the Commissioner multiplied by a standard salary and fringe benefit amount. • Capital costs determined using Medicare principles of	Providers may request rate adjustments if there are significant changes in service, programs, e.g., capital enhancements, staffing plan changes, changes in capacity, changes to meet JCAHO requirements.	Annual operating cost increases based on Medicare inflation factor for hospitals and units excluded from the PPS. Most recent update was 10/2023.

[238] https://health.ny.gov/regulations/state_plans/status/hospital/approved/docs/app_2020-11-23_spa_20-62.pdf; https://www.health.ny.gov/health_care/medicaid/rates/mental_hygiene/info/

PRTF						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				reimbursement, including depreciation and interest.		
Oregon[239]	Prospective.	Fee schedule.	Per Diem.	• Rates based on provider general ledger data for the most recent full year of operation from residential treatment programs that is collected and analyzed by an independent third party. The independent third party must analyze provider general ledger cost data and job classification and wage data. • Provider costs are analyzed by aggregating general ledger information from multiple residential treatment programs to identify relationships between direct care costs and other cost components such as employee benefits, training, transportation, and program-related facility costs. • Rates are calculated for each tier based on the amount and type of direct care hours, including active engagement hours and supervision hours.	N/A	Annually, the Division reevaluates provider general ledger data at 5-year increments; standardized rates may be trended annually based on the CPI that the State applies for the State minimum wage.

[239] https://secure.sos.state.or.us/oard/displayDivisionRules.action?selectedDivision=1740

PRTF						
Payer	**Rate Type**	**Basis of Payment**	**Unit of Payment**	**Methodology**	**Adjustments**	**Update Schedule**
				• The maximum allowable rate the Division pays per client under the standardized rate methodology is paid according to one of five rate tiers. Rate tiers are based on levels of need based on individual acuity, program type and capacity, and minimum wage region. • Administrative costs are capped at 10% of allowed costs. • Standardized rates include a 5% vacancy rate for providers to use as a reserve.		
Medicare	Medicare does not cover PRTF services.					