Connecticut Department of Social Services

Revised: Rate Study Overview and Results

January 2025

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Study Overview

- Assessment of the current Connecticut Medicaid methodologies, including the basis and components of rates and processes.
- Review of each of the codes in the fee schedule and the development of “benchmarks” for comparison.
- Results of analyses in Phase 2 include Phase 1 findings and findings from the Waiver Rate Study.
- Comparison analyses were based both on Medicare rates, where available, and a five-state average.
- Certain cost-based provider-specific methodologies were analyzed using an alternative approach.

Rate Study Definition and Purpose

What a rate study is not:

Does not enact any changes to programs as changes require legislative appropriations and federal approval

Does not make recommendations with respect to dollar amounts for any rates

Rather, it makes general recommendations regarding actions an agency or state could take to address rate disparities.

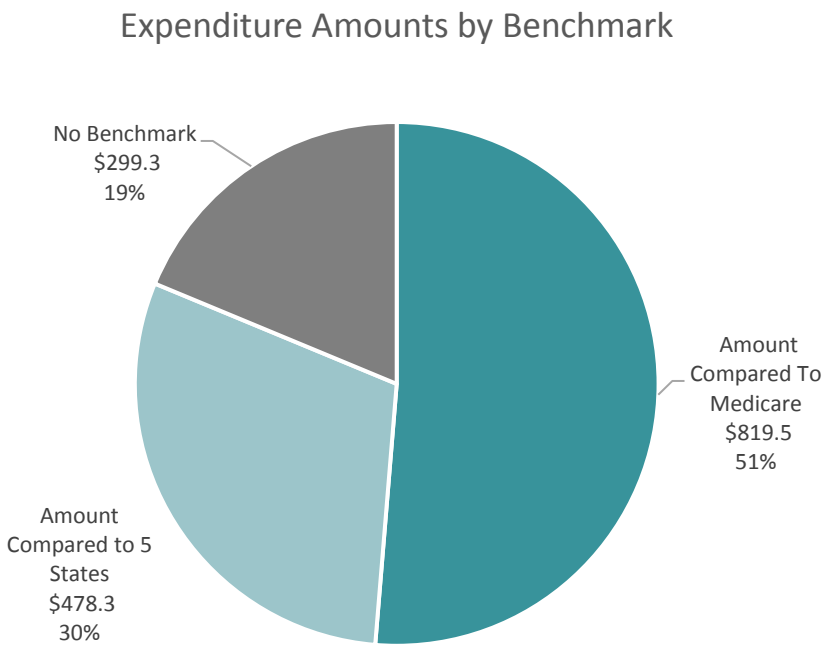
What a rate study is:

A data-driven review of Medicaid rate parity when compared to peer payers (Medicare and peer states)

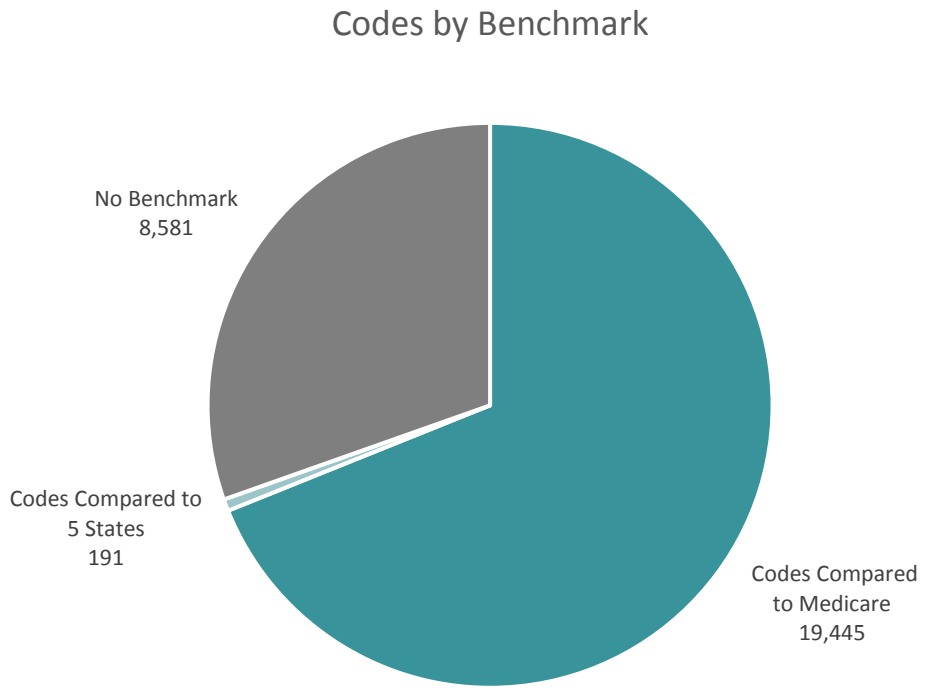
Identification of rates with the largest disparity when compared to the benchmark

Phase 2 Results

Myers and Stauffer compared codes representing about 81% of the benchmarked expenditures.



The majority of codes were benchmarked to Medicare.



Five states included in the comparison: New York, New Jersey, Maine, Massachusetts, and Oregon.

Phase 1 Results

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	Amount Expenditures would Increase	Percent Increase over Current Expenditures
Physician Outpatient Non Facility	$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	$179.3		$177.4	$0.9	$178.3	$0.0	0.0%

Phase 2 Results

Benchmark Summary Analysis ($ in Millions)							
Fee Schedule	Current Expenditures	Expenditures at 80% of Medicare	Expenditures at 100% Five- State Average	Expenditures Associated with Non-Matched Codes	Total Expenditures at Benchmark	Amount Expenditures Would Increase	Percent Increase over Current Expenditures
Acupuncture	$1.9	$2.8		$0.0	$2.8	$0.8	43.6%
Ambulatory Surgical Center	$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%
Durable Medical Equipment (DME)- Cures Act	$26.2	$11.3		$16.9	$28.2	$2.0	7.6%
DME (Non-Cures Act)	$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%

Phase 2 Results (Continued)

Benchmark Summary Analysis ($ in Millions)							
Fee Schedule	Current Expenditures	Expenditures at 80% of Medicare	Expenditures at 100% Five- State Average	Expenditures Associated with Non-Matched Codes	Total Expenditures at Benchmark	Amount Expenditures Would Increase	Percent Increase over Current Expenditures
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%
Chemical Maintenance	$52.1				$52.1		
Federally Qualified Health Centers	$280.6				$280.6		
Home Health (Revenue Codes)	$4.7				$4.7		
Hospice	$6.5				$6.5		
Intermediate Care Facility	$74.0				$74.0		
Inpatient Hospital (DRG)	$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		
Psychiatric Residential Treatment Facility	$11.9				$11.9		

Summary of Phases 1 and 2 Results

Benchmark Summary Analysis $ in Millions							
Fee Schedule	Current Expenditures	Expenditures at 80% of Medicare	Expenditures at 100% Five-State Average	Expenditures Associated with Non-Matched Codes	Total Expenditures at Benchmark	Amount Expenditures would Increase	Percent Increase over Current Expenditures
Total	**$5,471.1**	**$819.5**	**$478.3**	**$299.3**	**$5,770.7**	**$300.5**	**5.5%**
State Share *	**$2,735.6**	**$409.7**	**$239.2**	**$149.7**	**$2,885.3**	**$150.3**	

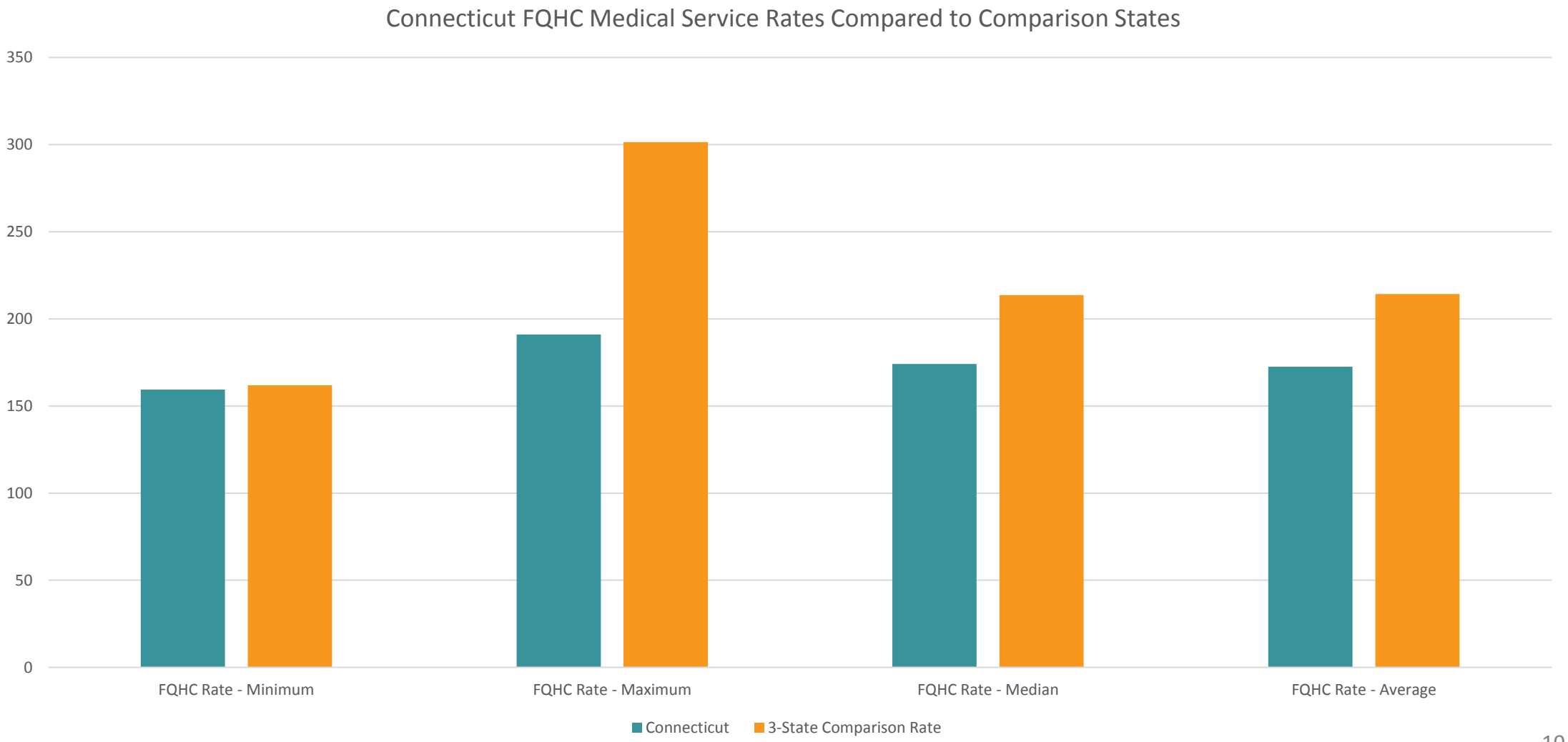
* Calculated at 50% to account for the federal medical assistance percentage (FMAP) as a conservative estimate of the state share necessary. Although 50% FMAP is the default FMAP for Connecticut's Medicaid program, certain populations and service categories have a higher FMAP.

Alternative Analyses

Some services were analyzed using an alternative analysis due to factors such as the use of cost-based rates, utilization of grouper software, lack of Medicare comparability, and other financing considerations such as use of alternative payment methodologies or supplemental payments. These services included:

- Chemical Maintenance Clinic
- **Federally Qualified Health Center** (FQHC)
- Hospice
- **Inpatient Hospital**
- Intermediate Care Facility (ICF) (Private)
- **Outpatient Hospital**
- Psychiatric Residential Treatment Facility (PRTF) (Private)

FQHC Comparison



FQHC Medical Rate Comparison

Comparison of FQHC Medical Encounter Rates: Connecticut vs Selected Comparison States (% Relative to Connecticut)								
	CT	ME		NJ		NY		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%

FQHC Dental Rate Comparison

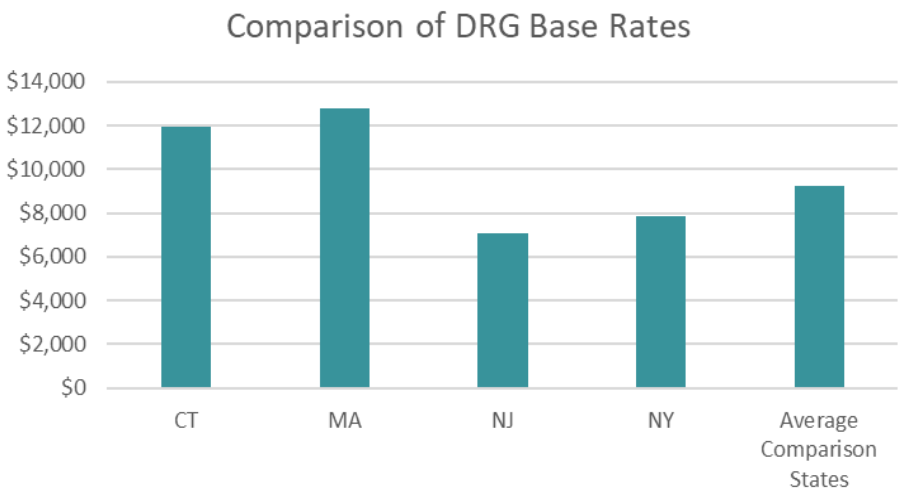
Comparison of FQHC Dental Encounter Rates: Connecticut vs Selected Comparison States (% Relative to Connecticut)									
	CT	ME		NJ		NY		Average of Comparison States	
Rate Statistic	Rate	Rate	CT rate as a percent of Comparison Rate	Rate	CT rate as a percent of Comparison Rate	Rate	CT rate as a percent 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%

FQHC Behavioral Health Rate Comparison

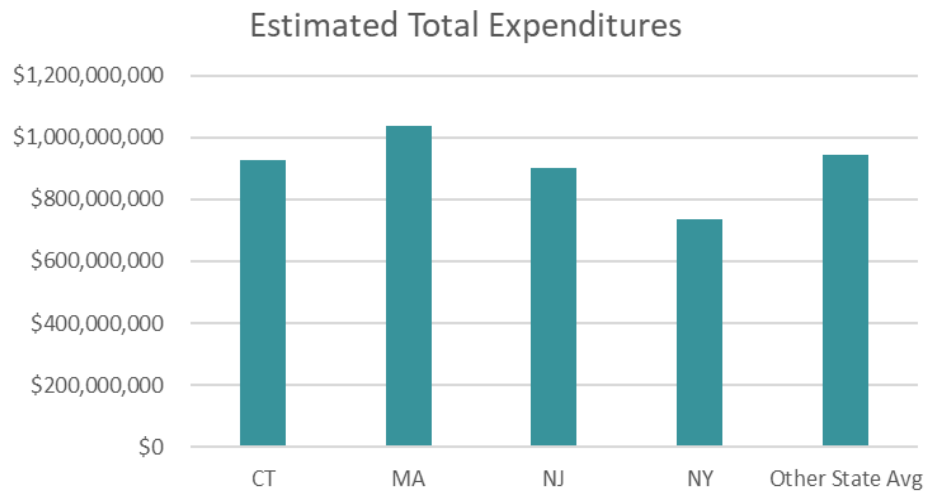
Comparison of Behavioral Health Encounter Rates: Connecticut vs Selected Comparison States (% Relative to Connecticut)									
Rate Statistic	CT	ME		NJ		NY		Average of Comparison States	
	Rate	Rate	CT rate as a percent of Comparison Rate	Rate	CT rate as a percent of Comparison Rate	Rate	CT rate as a 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%

Inpatient Hospital Comparison Results

	CT	MA	NJ	NY	Average of Comparison States
Median Base Rate	$11,954.50	$12,810.86	$7,046.96	$7,881.86	$9,246.54
CT as % of Comparison Rate		**93%**	**170%**	**152%**	**129%**



	CT	MA	NJ	NY	Average of Comparison States
Estimated Total Expenditures	$928,545,868	$1,034,769,919	$901,739,022	$737,319,530	$944,620,767
CT as % of Other States		**90%**	**103%**	**126%**	**98%**
Expenditures per Claim	$11,110.20	$12,381.19	$10,789.45	$8,822.14	$11,302.54

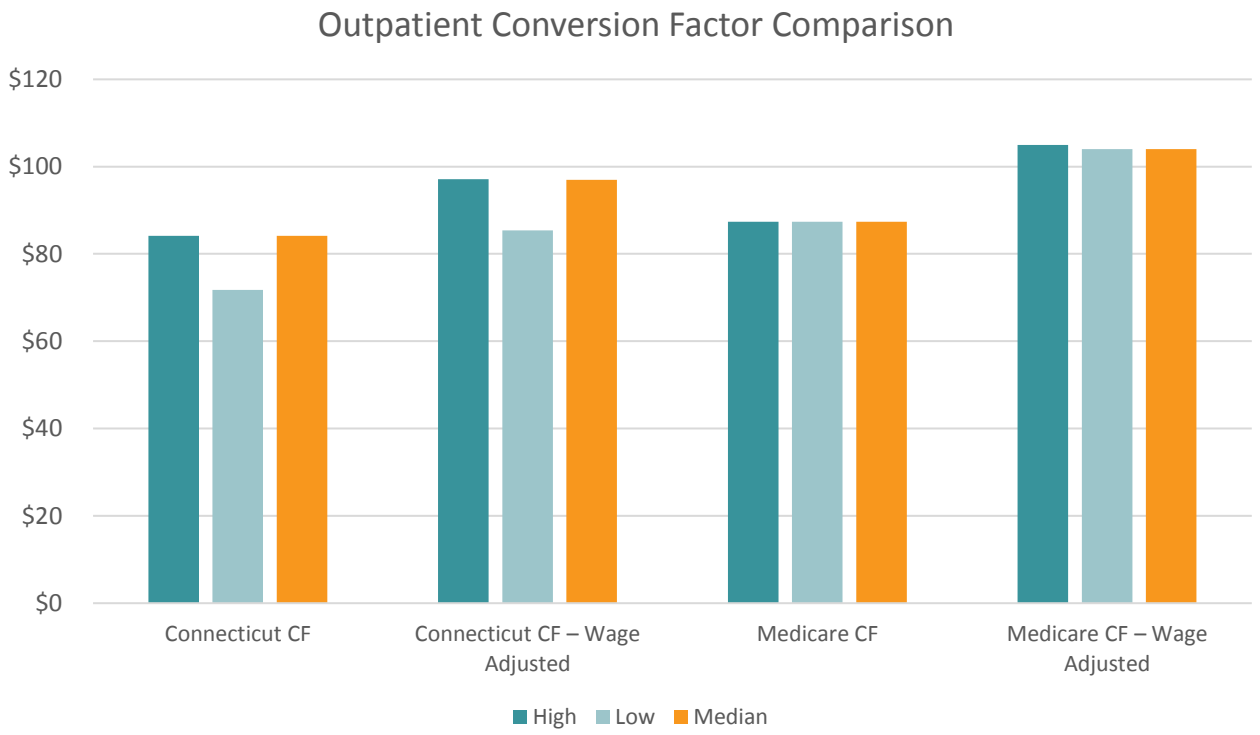


Note: Analysis does not factor in outliers, medical education, and other add-ons.

Outpatient Hospital Comparison Results

Connecticut utilizes the Medicare APC relative weights but has different conversion factors than Medicare.

	Connecticut Conversion Factor (CF)	Connecticut CF – Wage Adjusted	Medicare CF	Medicare CF – 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%				



Home and Community-Based Services (HCBS) Models

Phase 1: DSS Waivers

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%

Waivers included in Phase 1 of the HCBS Waiver Rate Study:

- Acquired Brain Injury 1 and 2
- CT Homecare Program for Elders
- Katie Beckett
- Mental Health
- Personal Care Assistance
- Persons with Autism

HCBS Models

Phase 2: DDS Waivers

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%

Waivers included in Phase 2 of the HCBS Waiver Rate Study:

- Comprehensive Supports
- Employment and Day Supports
- Individual and Family Supports

Findings and Recommendations

Fee Schedule Development and Use

Findings

- 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.

Recommendations

- 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 or other relevant Medicare fee schedule.
- Develop a timetable for the review and/or updating or rebasing of rates to achieve greater equity across providers.
- For rates where Medicare does not provide a methodologically sound approach for updating rates, update rates using other state's Medicaid 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.

Cost-Based and Provider-Specific Reimbursement

Findings

- 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.

Recommendations

- For rate methodologies that were analyzed using an alternative approach, continue the rate updates and rebasing to maintain the integrity of the methodologies and resulting fee schedules.

Fee Schedule Maintenance

Findings

- 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.

Recommendations

- Combine all the fee schedules paid using the Medicare Physician Fee Schedule (PFS) into one fee schedule. Do the same for 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

Findings

- DSS' administrative services organizations monitor access to services using geo-mapping and other tools and reviews complaints regarding member access; targeted access issues are addressed as they arise and are not considered to be caused by fee schedule issues.

Recommendations

- Investments will be targeted to areas where there are known access issues. DSS will continue to monitor access issues and ensure those investments – and any additional investments – improve the Medicaid member's experience and access to services as fee schedule methodologies and rates are changed.

Value-Based Purchasing Incentives

Findings

- 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.

Recommendations

- 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.

HCBS Waiver Services

Findings

- 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.
- Review waiver eligibility and service planning tools to ensure alignment with best practices.*

**DSS uses the person-centered interRAI assessment tool for participants in DSS waivers. DDS and DMHAS use standardized assessment tools for administration of waiver programs.*

Recommendations

- 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.

Next Steps

The rate study findings are intended to provide a measurement and guide for further analysis. They provide a point of reference that should be considered, along with other measurements of patient access and Medicaid performance, to inform policy decisions. The rate study does not suggest specific fee schedule rate increases or specific Medicaid policy recommendations but can be used as a guide to determine where funding can best be targeted to improve any identified access issues and improve quality, outcomes and, ultimately, reduce spending on acute care services.

Over the next year, the Department will continue engagement with interested stakeholders and will begin deeper analyses in the following areas: *Details pending and will be shared once developed.*

- Conduct, with our state agency partners, a comprehensive analysis of home and community-based services waiver rates, as well as options to better manage the dually eligible population.
- Develop rate review process to monitor for market changes, new cost information, and that rates fall within the benchmark percentage and develop a timetable for the review and/or update of fee schedules to achieve greater equity across providers.

Next Steps continued

- Reestablish rate parity for behavioral health (clinic, private practitioners, children, and adults) services between children and adults – Medicaid is available for eligible individuals of all ages and the recent increase to services only for children in phase one will result in cliffs where children suddenly lose access to services when they become adults.
- Explore rate adjustments for certain physician fees to provide a strong foundation and provider base with access to core services.
- Base rates to a percentage of Medicare to ensure that fee schedule services fall within a specified and more current benchmark (many fee schedules are currently based on a percentage of 2007).
- Inventory current access monitoring tools and identification of improvements to support improved outcomes for members
- Review alternative payment methodologies that include incentives to improve the quality and overall value of services provided to members, including improving cost containment, reducing avoidable hospitalization, and addressing chronic conditions.


Q&A