

# DSS MAPOC PRESENTATION

MAY 8, 2026

# Agenda Items

- **H.R. 1 General Updates** (Deputy Commissioner Peter Hadler)
  - Technology Procurement – (Deputy Commissioner Easha Canada)
  - SNAP Impact
  - Medicaid Impact
  - Outreach Initiatives
- **Pharmacy Updates** (Dr. Jody Terranova)
  - Prior Authorization Pilot Findings
- **Rate Increases and Rate Review & Evaluation Roadmap** (Nicole Godburn)
  - FY26 Increases to date
  - Medicaid Rate Study Evaluation

# H.R. 1 GENERAL UPDATES

## TECHNOLOGY PROCUREMENT

# H.R. 1 Technology Procurement

- Executed extremely rapid 8-week competitive procurement cycle to identify vendor for implementation of major HRI-related system changes
- Preferred vendor identified from among 10 bidders
- Statement of Work (SOW) signed
- Currently in discovery/alignment phase (5/4 – 5/29)
- In parallel, executing a system implementation governance structure and delivery calendar across multiple DSS divisions, Access Health CT, and vendor partners
- Working closely with CMS to ensure expedited contract review and approval pursuant to the initial approved Advanced Planning Document (APD)

# H.R. 1 GENERAL UPDATES

## SNAP IMPACT

# SNAP Work Requirement Changes

## Previous State:

- Adults 19 to 54 must prove that they are engaged in 80+ hours per month of work or community engagement
- Exempts adults with children under age 18
- Exempts veterans, those experiencing homelessness, and those under 24 who aged out of foster care at 18
- Allows waivers for certain towns/areas that lack sufficient jobs

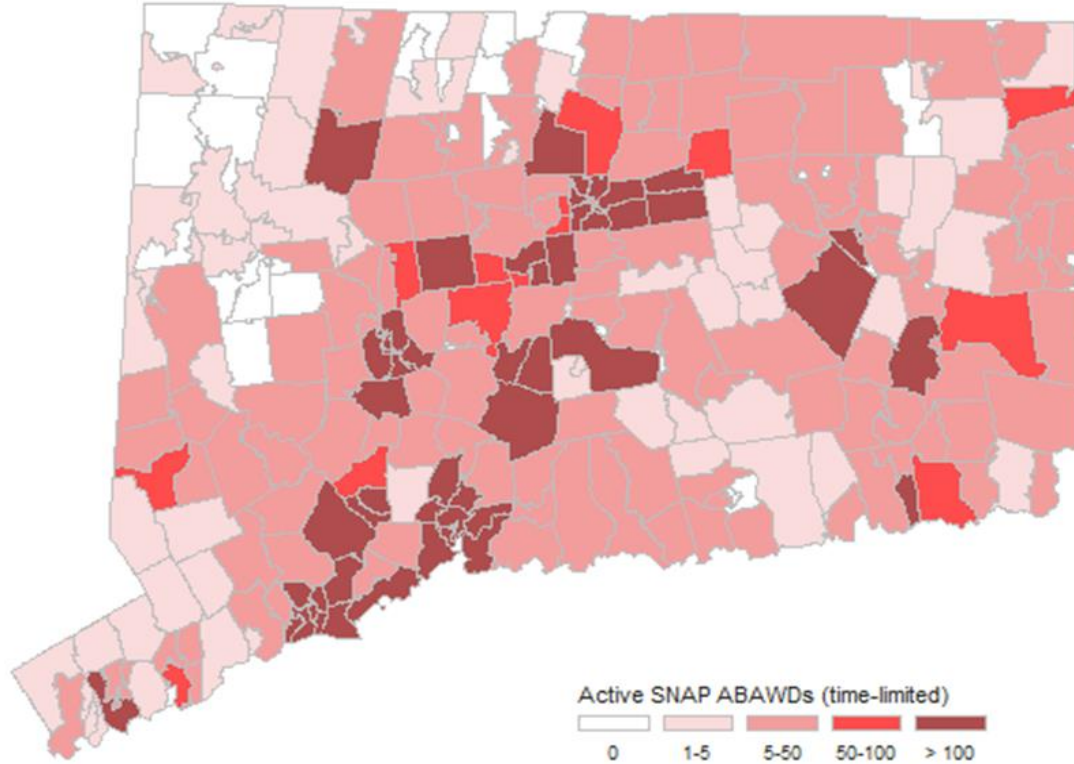
## Current State:

- Adults 19 to **64** must prove that they are engaged in 80+ hours per month of work or community engagement
- Changes exemption to adults with children under age **14**
- **Removes exemptions** for veterans, those experiencing homelessness, those under 24 who aged out of foster care at 18
- **Limits geographic waivers** to towns/areas that have an unemployment rate > 10%

# SNAP Participation Geographic Impact

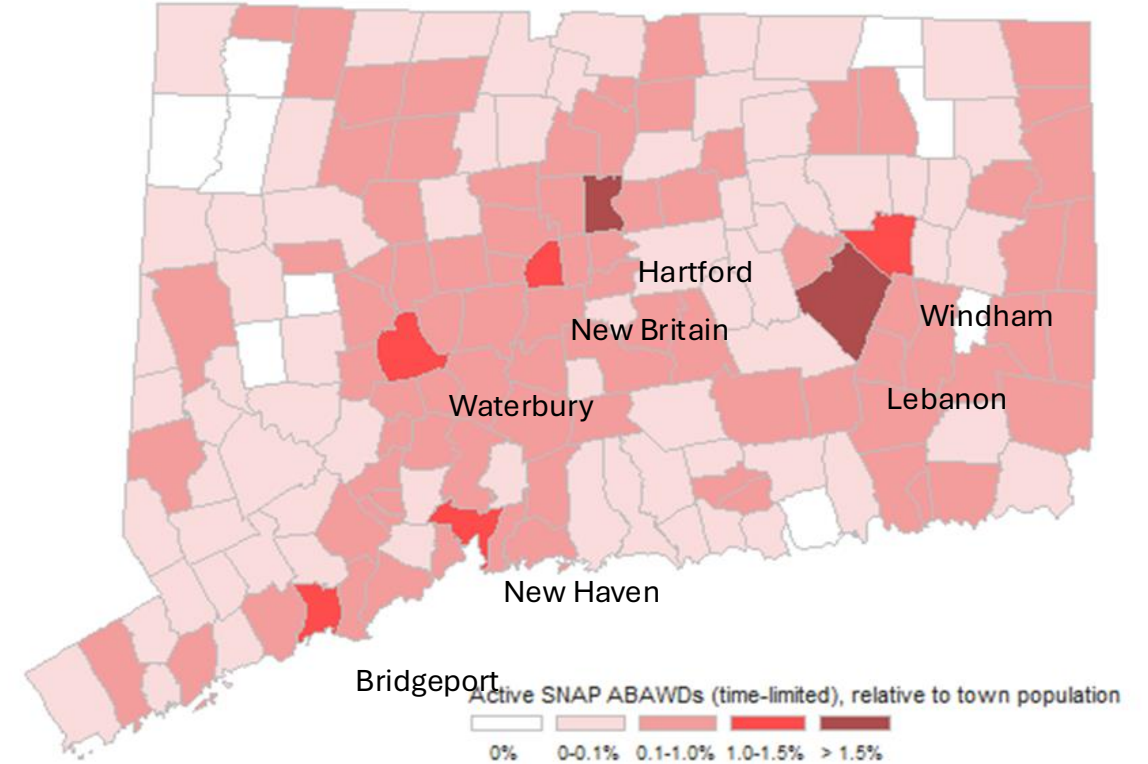
## Total population impacted

CT SNAP beneficiaries: Time-limited due to ABAWD work requirements (3-month time limit)



## Percentage of town population impacted

CT SNAP beneficiaries: Time-limited due to ABAWD work requirements (3-month time limit)



Due to the timing of the data extract, these figures demonstrate members shifting to time-limited benefits, not closures. However, these figures approximate closures, based on the participation change data presented on the next slide.

# SNAP Participation Changes by Month

- Work requirement exemptions were removed primarily around **December 2025** and **April 2026**.
- **17,000 beneficiaries** shifted to time-limited status after the December 2025 exemption changes. About **15,000** of them lost benefits by April 2026 while 2,000 retained benefits.
- **10,000 more** shifted to time-limited status in April.
- 2,000 to 3,000 other time-limited beneficiaries lost benefits between January and April. Based on historical trends, these are probably unrelated to H.R.1 changes specifically.

Month	All SNAP Beneficiaries ( <b>thousands</b> )			Time-limited SNAP Beneficiaries ( <b>thousands</b> )		
	Total SNAP beneficiaries	New to SNAP (No benefits in previous month)	No longer in SNAP (Had benefits in previous month)	Total time-limited <sup>1</sup>	New to time-limited status (Had <u>non time-limited</u> benefits in previous month)	No longer in SNAP (Had <u>time-limited</u> benefits in previous month)
Oct '25	342	NA	NA	1	NA	NA
Nov '25	335	9	15	1	<1	<1
Dec '25	331	11	15	19	17	<1
Jan '26	326	11	16	18	1	2
Feb '26	321	10	14	18	1	2
Mar '26	318	11	15	17	1	3
Apr '26	303	11	25	16	10	11

<sup>1</sup> The "Total time-limited" count includes: (1) individuals who entered the SNAP program as time-limited beneficiaries; (2) individuals who remain time-limited beneficiaries; and (3) individuals that became time-limited beneficiaries after previously receiving benefits with no time limits. This last category is explicitly shown in the "New to time-limited status" column.

# H.R. 1 GENERAL UPDATES MEDICAID IMPACT

PROJECTIONS FOR FEDERAL CHANGES REQUIRED BY 2027

# Medicaid Work Requirements

## Current State:

- No work or community engagement requirements for Medicaid eligibility in Connecticut

## Future State:

- **Starting January 1, 2027**, HUSKY D enrollees (~316,000 members) will need to meet work requirements or community engagement rules to get or keep coverage
- **Work/income:** Proof of at least 80 hours/month of work or income of at least \$580/month (federal minimum wage x 80hrs)
- **Community engagement:** Proof of at least 80 hours/month of community service or a qualified work or training program; enrolled at least half-time in an education program; or any combination of community engagement and work totaling at least 80 hours per month

# Medicaid Work Requirement Exemptions

- Veterans with disability rated as total
- Medically frail (e.g., blind, disabled, children with serious emotional disturbances, adults with serious mental illness, chronic substance use disorders, serious and complex medical conditions)
- Participating in approved drug or alcohol treatment and rehabilitation program
- Already meeting work requirements for SNAP and/or TFA
- Parent/caregiver of an individual with a disability
- Individuals recently released from incarceration in the last 90 days
- Certain Native American & Alaska Native populations
- Foster and former foster youth
- Short-term hardship waivers (e.g., individuals receiving medical care out of state)

# Medicaid Work Requirements

Preliminary estimates  
subject to change

Using data already available in state systems to assess Medicaid work requirement impacts, we estimated that...

- **Previous analysis:** Roughly 50% of HUSKY D low-income adults are likely exempt or compliant
- **Updated analysis:** 65% of HUSKY D low-income adults are likely exempt or compliant

## Updated analysis: February 2026 Data

HUSKY D Low-income adults	February 2026 Members	% Total
At-risk of coverage loss	110 k	35%
Likely exempt or compliant using available data	206 k	65%
<b>Total distinct Medicaid members</b>	<b>316 k</b>	<b>100%</b>

The updated analysis includes the following changes:

- **HUSKY membership:** More recent cohort of HUSKY Health members from February 2026
- **SNAP beneficiaries:** Medicaid members are exempt if they already comply with SNAP work requirements

→ Previously, this had not been included since SNAP work requirement changes had not gone into effect

- **Medical frailty:** Medicaid members are exempt from work requirements in certain medical instances (upcoming slide)

→ Previously, medical frailty had been defined using 460 diagnosis codes; a more comprehensive list of >4,000 codes have been considered based on national proposals

# Medicaid Work Requirements

Preliminary estimates  
subject to change

HUSKY D Low-income adults	February 2026 Members	% Total
<b>At-risk of coverage loss</b>	<b>110 k</b>	<b>35%</b>
<b>Likely exempt or compliant using available data <sup>1</sup></b>	<b>206 k</b>	<b>65%</b>
Medical Frailty <sup>2</sup>	126 k	40%
Wage records <i>Monthly income at least federal minimum wage x80 hours</i>	94 k	30%
SNAP beneficiary <i>Complying with SNAP work requirements</i>	45 k	14%
Other eligibility factor <i>Non-Medicaid expansion (26k), Not 19-64 (9k), Medicare (5k), cash assistance (3k)</i>	39 k	12%
Supplemental Security Income (SSI) <i>Indicates a qualifying disability exemption</i>	24 k	8%
Student <i>Full-time or half-time (data primarily from SNAP)</i>	6 k	2%
<b>Total distinct HUSKY D members</b>	<b>316 k</b>	<b>100%</b>

Categories are **not** mutually exclusive

**Among the 206k members, 88k members are likely exempt or compliant based on multiple categories.**

<sup>1</sup> Other exclusion criteria for future consideration include drug/alcohol treatment center, recent release from incarceration, Tribe members, veteran with rated disability, and parent/caretaker of individual with disability.

<sup>2</sup> As DSS finalizes a list of codes for medical frailty determinations, the approach above uses a diagnosis codes that are either in [Michigan's alternative benefit plan \(ABP\) codes](#) or in both (1) the Harvard-refined set of Chronic Conditions Data Warehouse (CCW) codes, and (2) NAMD-shared diagnosis codes recommended by a consortium of western states. Up to 12 months of Medicaid claims data are used to identify presence of (at least one) qualifying diagnosis codes.

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## Medical Frailty

Medical frailty is defined in 42 CFR §440.315(f) as having any of the following:

- Substance-use disorder
- Disabling mental disorder
- Physical, intellectual, or developmental disability that significantly impairs one or more activities of daily living
- Serious or complex medical condition
- Blind or disabled (per SSA §1614)

Ahead of potential specifications from federal regulations in June 2026, DSS has reviewed national proposals for using claims data (e.g., diagnosis codes) to help implement the definition above.

Using these proposals, **the updated analysis now considers over 4,000 diagnosis codes that appear in multiple proposals.** This approach is subject to change with regulatory guidance.

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**H.R. 1 GENERAL UPDATES  
OUTREACH INITIATIVES**

# CAA CHW Navigators Outreach Initiative

- Funded through emergency funds established in the November 2025 special session to help mitigate the impact of federal cuts
- Contract with the state's **Community Action Agencies (CAAs)** to hire and train Community Health Worker (CHW) navigators to help individuals and families understand and meet H.R. 1's new work requirements and eligibility rule changes to stay connected to benefits
- CAA CHW navigator services include:
  - **On-ground community outreach**
  - **Workrequirement and eligibility education**
  - **Vocational and volunteer opportunities**
  - **direct case management, including wraparound assistance for other barriers**
- The CHW training event kick off occurred on April 23, 2026

# SNAP–Medicaid Texting Outreach Pilot Program

- Currently conducting a four-month pilot program in partnership with **Yale University's SCALE Lab**, **Connecticut Foodshare**, and **Frontdoor Benefits** with the goal of increasing SNAP enrollment and evaluating varied communication techniques
- **Text message outreach to 50,000 Medicaid members** (randomly identified) not currently on SNAP who were randomly assigned to receive 1 of 3 types of text message:
  - **Info Only**: notifying members of potential SNAP eligibility and directing them to DSS' ConneCT client portal to apply (~10K)
  - **Info + Assistance**: notifying members of potential eligibility plus option to connect with Connecticut Foodshare by phone for direct enrollment assistance (~10k)
  - **Digital Navigation**: notifying members of potential eligibility and directing them to Frontdoor Benefits for mobile app self-enrollment and assistance (~30k)
    - Also includes **one reminder text message** the following week to prompt members to apply if they have not already.

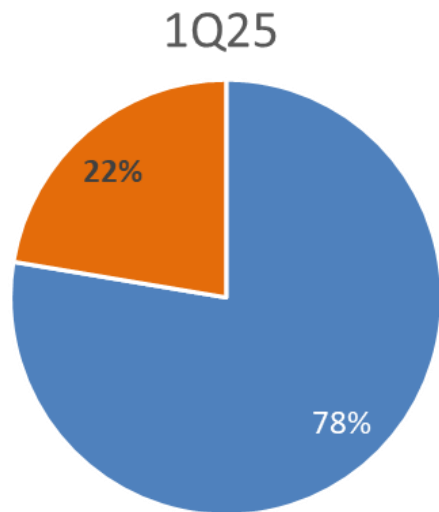
**PHARMACY UPDATES**  
**PRIOR AUTHORIZATION PILOT FINDINGS**  
**1ST QUARTER – 2025 V. 2026**

# Pharmacy Pilot Data Findings

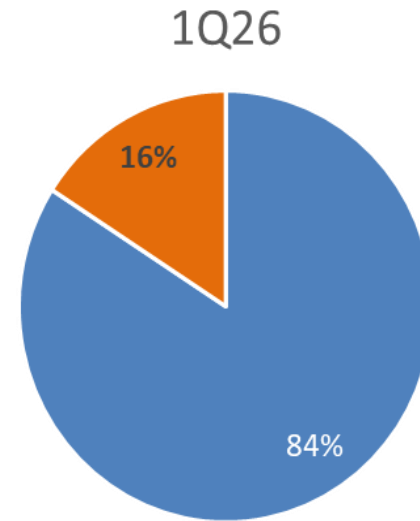
- As of January 1, 2026 new prescriptions for non-preferred drugs in 11 drug classes now require submission of clinical information along with the prior authorization form.
- Members on medications in these 11 drug classes, as of December 31, 2025, were grandfathered during the 1<sup>st</sup> quarter of 2026 if their former prior authorization was due to expire to mitigate negative member impacts.
- **Data Comparison** – to assess the pilot's impact, DSS looked at:
  - **2025 1st Quarter:** New prescriptions in the 11 drug classes under the former prior authorization process
  - **2026 1st Quarter:** New prescriptions in the 11 drug classes under the new clinical criteria prior authorization process

# Summary Findings of 11 Drug Classes in Pilot

Totals	New Member 2025 1st Qtr (1Q25)	New Member Start 2026 Qtr (1Q26)	1Q25 Preferred %	1Q26 Preferred %
Preferred	13,724	12,426	77.6%	84.1%
Non-Preferred	3,956	2,351		



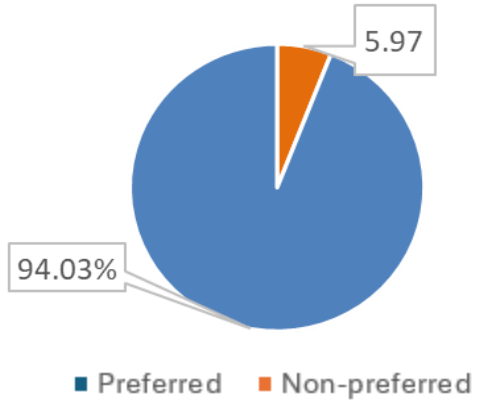
■ Preferred ■ Non-preferred



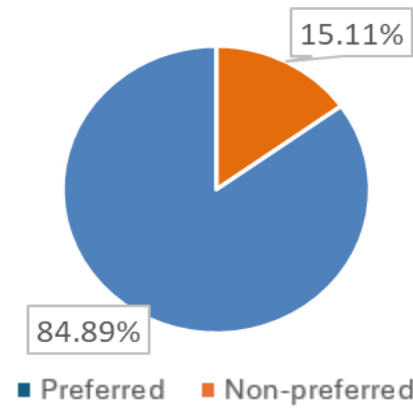
■ Preferred ■ Non-preferred

# Summary Findings of 11 Drug Classes in Pilot

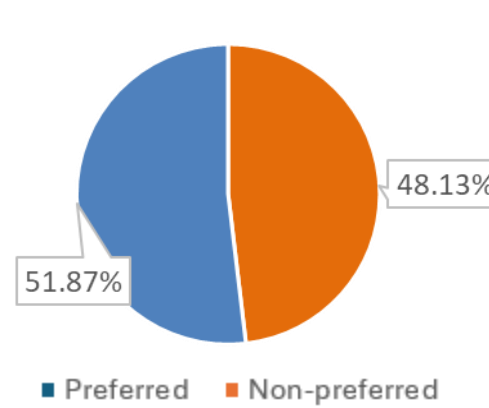
1Q25 ANTICONVULSANTS



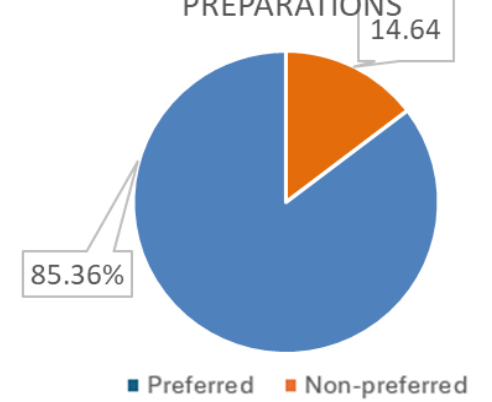
1Q25 ANTIMIGRAINE, OTHER



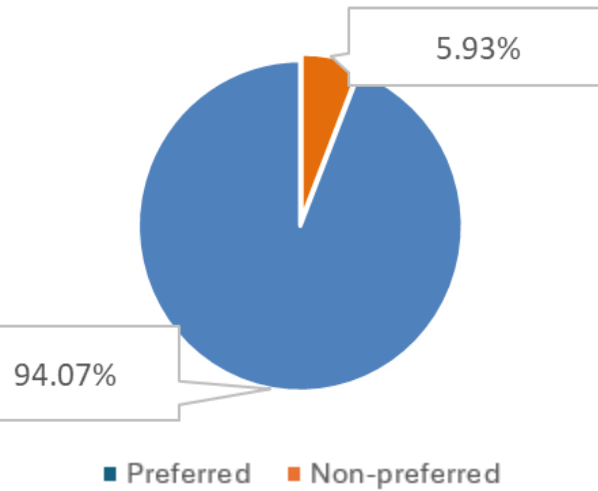
1Q25 ANTIPSORIATICS, TOPICAL



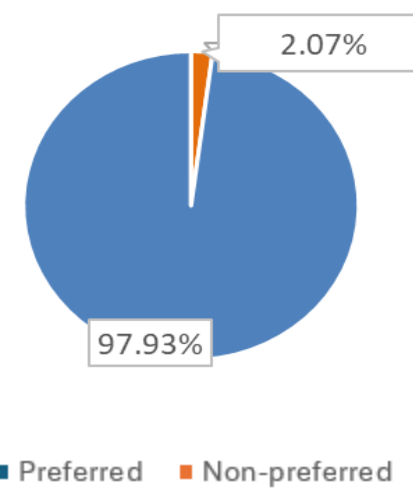
1Q25 BLADDER RELAXANT PREPARATIONS



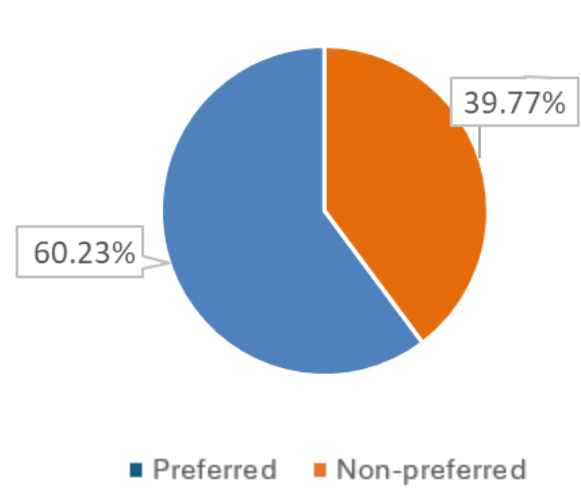
1Q26 ANTICONVULSANTS



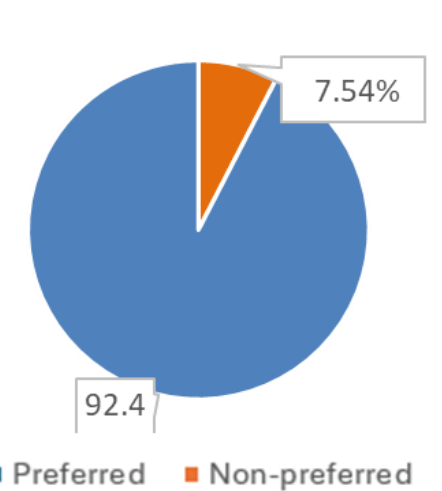
1Q26 ANTIMIGRAINE, OTHER



1Q26 ANTIPSORIATIC, TOPICAL

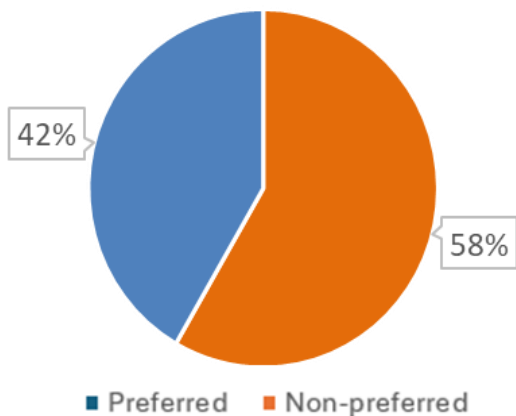


1Q26 BLADDER RELAXANT PREPARATIONS

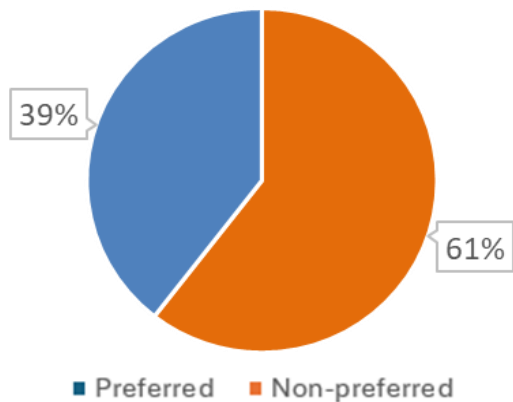


# Summary Findings of 11 Drug Classes in Pilot

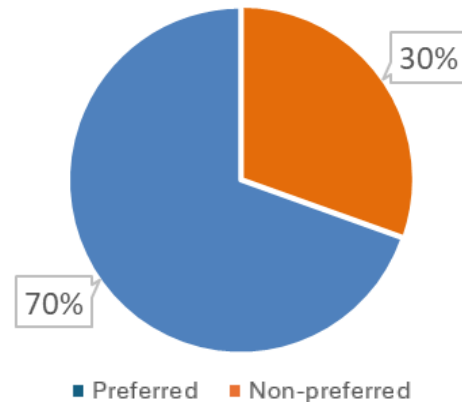
1Q25 COLONY STIMULATING FACTORS



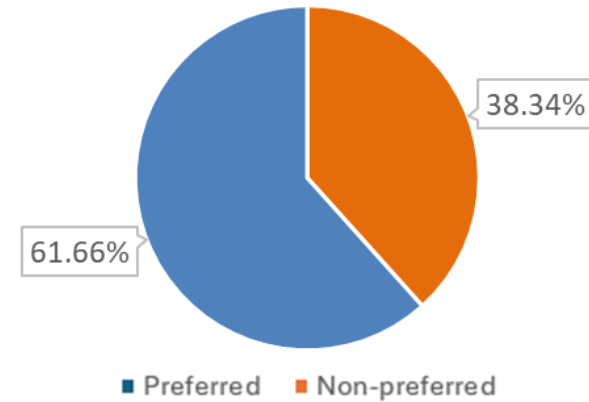
1Q25 CYTOKINE AND CAM ANTAGONISTS



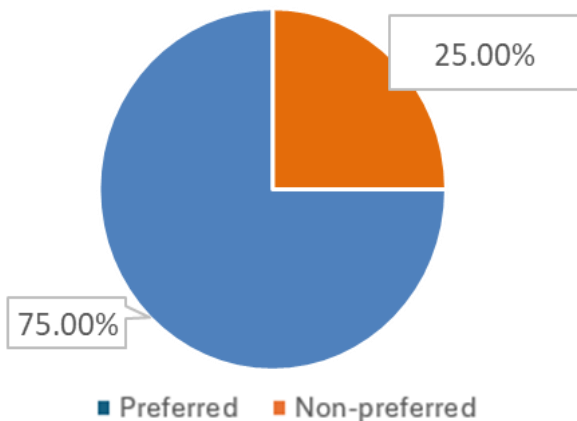
1Q25 GROWTH HORMONE



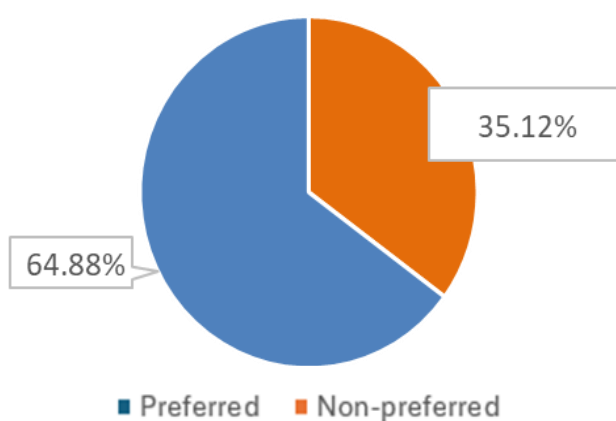
1Q25 HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS



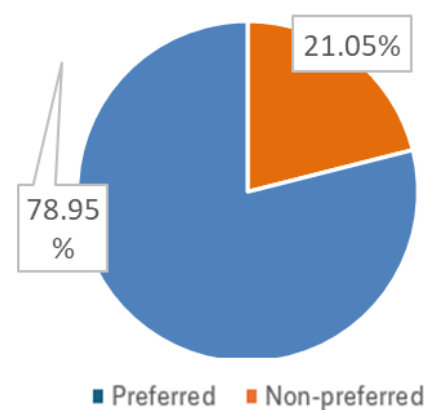
1Q26 COLONY STIMULATING FACTORS



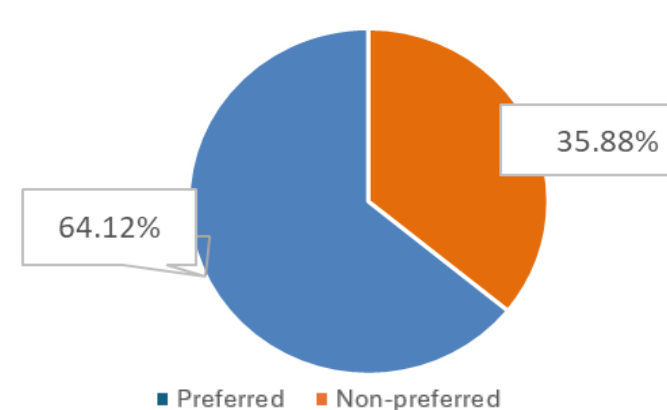
1Q26 CYTOKINE AND CAM ANTAGONISTS



1Q26 GROWTH HORMONE

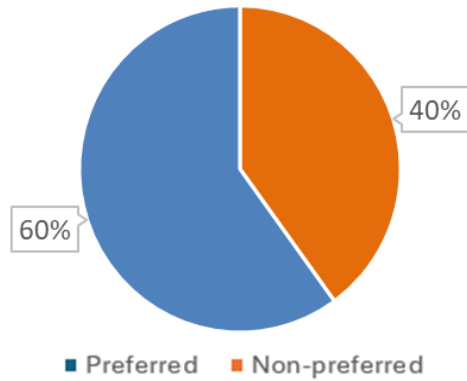


1Q26 HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS

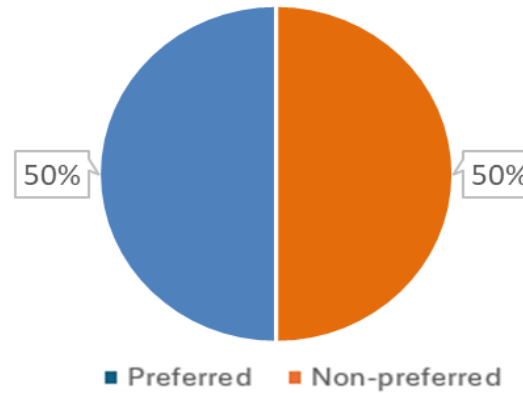


# Summary Findings of 11 Drug Classes in Pilot

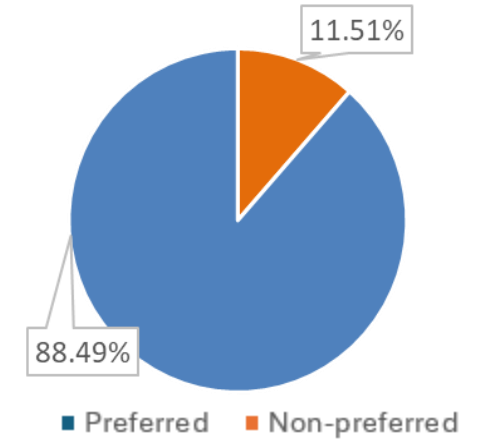
1Q25 MULTIPLE SCLEROSIS AGENTS



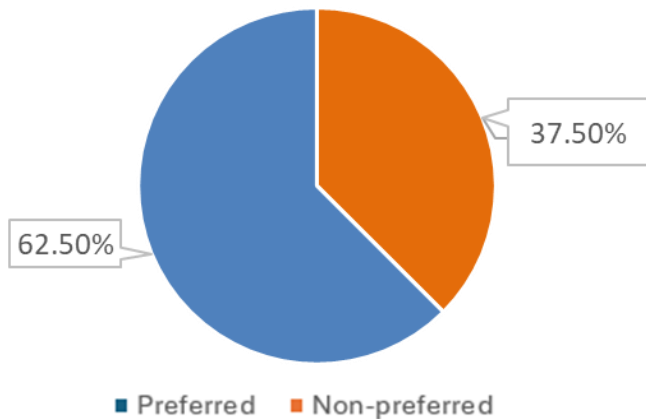
1Q25 PAH AGENTS, ORAL AND INHALED



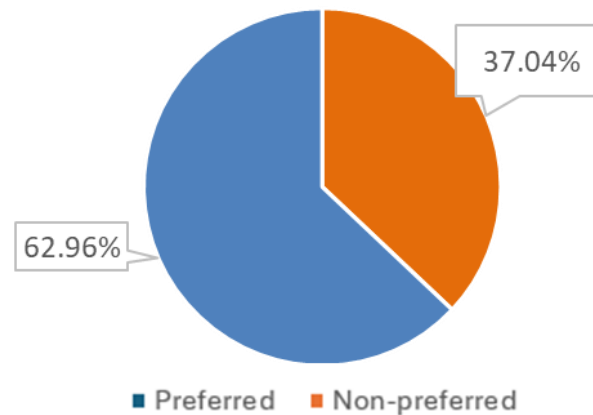
1Q25 IMMUNOMODULATOR, ASTHMA, ATOPIC DERM



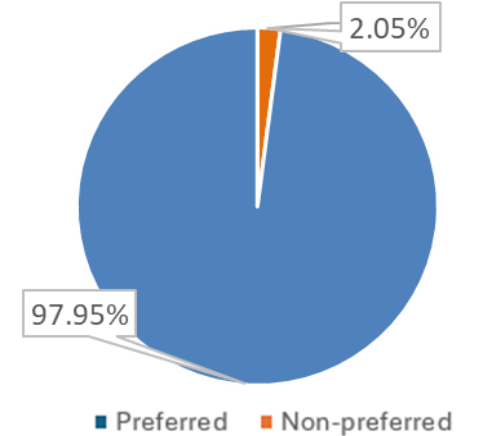
1Q26 MULTIPLE SCLEROSIS AGENTS



1Q26 PAH AGENTS, ORAL AND INHALED



1Q26 IMMUNOMODULATORS, ASTHMA, ATOPIC DERM



# Findings Summary

**All 11 drug classes saw an increase in the percentage of new prescriptions with preferred drugs used compared to prior year**

- Colony stimulating factors and Cytokine & CAM Antagonists had the largest shifts:
  - Colony stimulating factors: 42% ->75%
  - Cytokine & CAM Antagonists: 39% -> 65%
- Anticonvulsants had the smallest shift: 94.03% -> 94.07%

# Findings Analysis

**We continue to actively collect and assess pilot program data.**

Future analysis includes reviewing:

Rates of approvals and denials

Rates of rx fill with a preferred drug when a non-preferred is not authorized

Data for members grandfathered during 2026 1Q



**RATE REVIEW & RATE EVALUATION ROADMAP**  
**MEDICAID RATE STUDY**

# Medicaid Rate Study Recommendation

The **Medicaid rate study** was conducted with support from Myers & Stauffer between 2023–2025.

- Phase 1 was released February 2024
- Phase 2 was released January 2025
- The rate study benchmarked Connecticut Medicaid rates to Medicare and peer states when applicable



Rate study benchmarking is a vital, data-driven tool used by many state Medicaid programs to support Medicaid policy makers in the development of rational rate setting methods that support access to services, and quality outcomes for Medicaid members.

- The rate study identified that:
  - **Rate changes were mandated on an isolated case-by-case basis** through legislation or funded by specific state budget appropriations resulting in some areas of the program receiving significantly more frequent rate increases without any evidence-based assessment.
  - **The current system does not include timelines for fee schedule 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 DSS to track rates on an ongoing basis.

# Medicaid Rate Study Recommendation

The rate study specifically noted:

**"The current system forces the Department to focus its limited administrative resources in implementing isolated mandates and is not able to address program priorities proactively and comprehensively such as member and provider experience."**

The rate study's major recommendation was:



**Establish a formal rationale and comprehensive rate setting process that periodically reviews Medicaid rates known as a Medicaid Rate Evaluation Process.**

# Medicaid Rate Evaluation Process

The **Medicaid rate evaluation process** does the following:

- 1. Provides a set schedule** for regular rate review and adjustment of Medicaid rates paid to all Medicaid providers.
- 2. Formalizes a clear and transparent process for rate determination** via public notice, presentation, and public comments on proposed rates or program changes.
- 3. Ensures review of relevant state and national data to inform** rate amounts and payment models, with emphasis on models that promote high value services, member access and explores value-based reimbursement when appropriate.
- 4. Produces an annual report that includes DSS' recommendations** on rate adjustments, any increase in compensation for Medicaid providers, and a description of the data and methodology used to reach such recommendations.

# Medicaid Rate Evaluation Process

- The review and development of new methodologies and rates adjustments requires:
  - Significant personnel time and resources
  - State funding
  - Stakeholder discussion
  - Policy & rulemaking
  - Administrative and programmatic changes in our Medicaid Management Information System (MMIS)
  - Federal state plan approval with CMS
    - Rate review and adjustments cannot be implemented at the same time from an operational, administrative, or a financial perspective.

**By grouping fee schedules together, DSS developed an evaluation schedule that establishes more transparency and a predictable timeline for the provider community, the legislature and DSS.**

**RATE REVIEW & RATE SETTING ROADMAP**  
**FY26 INCREASES TO DATE**

# FY 26 and FY 27 Rate Increases

- The **rate study** recommended that rate adjustments made outside of the rate setting cadence should be made when there is a need to support member access to services and/or to focus on improved health outcomes and policy goals for member care.
- Services listed below will be reviewed in the later years of the rate evaluation process but have been identified for interim increases for access reasons or to support policy goals and/or member outcomes. Note: Rate increases below are before any new dollars added in the recent budget.

Service/Provider Type	FY 2026	FY 2027
Adult Dental	\$170,000	\$1,000,000
Birth Center Facility Fees	\$80,000	\$480,000
Collaborative Care Model – Primary Care	-	\$800,000
Collaborative Care Model – FQHC	-	\$200,000
Obstetrics Pay-for-Performance Program	\$120,000	\$120,000
Chronic Disease / Chronic Disease Hospital (LTACH)	\$1,030,000	\$6,800,000

# FY 26 and FY 27 Rate Increases

- Services listed below were reviewed as part of the rate analysis in addition to services that have been identified for interim rate increases based on access reasons or to support policy goals and/or member outcomes.

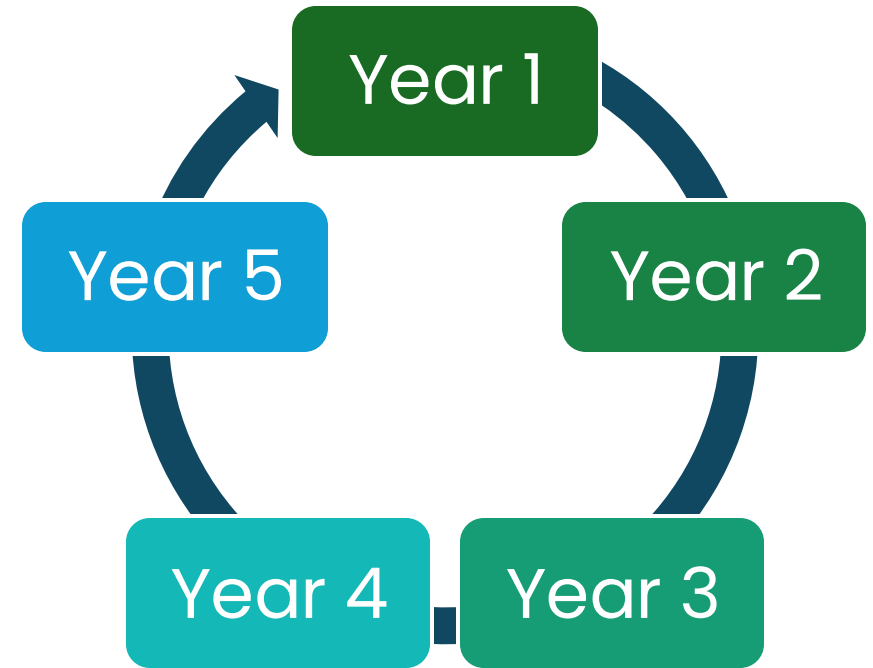
Service/Provider Type	FY 2026	FY 2027
Physician Fee Schedule (Primary Care / Specialty / Surgery)	\$5,500,000	\$12,600,000
FQHC Rates	\$5,000,000	\$12,000,000
Therapy Services (PT, OT, Speech)	\$500,000	\$2,000,000
Family Planning	-	\$1,000,000
Adult Behavioral Health	\$2,000,000	\$5,000,000
Child Behavioral Health	\$1,000,000	\$3,000,000

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**RATE REVIEW ROADMAP  
5-YEAR EVALUATION CYCLE**

# Medicaid Rate Evaluation Process

- Rate evaluations will take place over a **5-year cycle**
  - By the end of the cycle, the entire Medicaid program will have been evaluated.
  - The evaluation process is designed to gather recommendations at the end of the evaluation year. Recommendations are carried into the following state budget year for discussion regarding available funding for rate adjustments.
- Although state budget cycles may not align with rate evaluation years, providers are not passed over and are still evaluated for rate consideration.
  - **Recommendations will be made for rate adjustments every year**
- Upon completion of each 5-year cycle, DSS will commence a new 5-year cycle following the same transparent and predictable schedule.

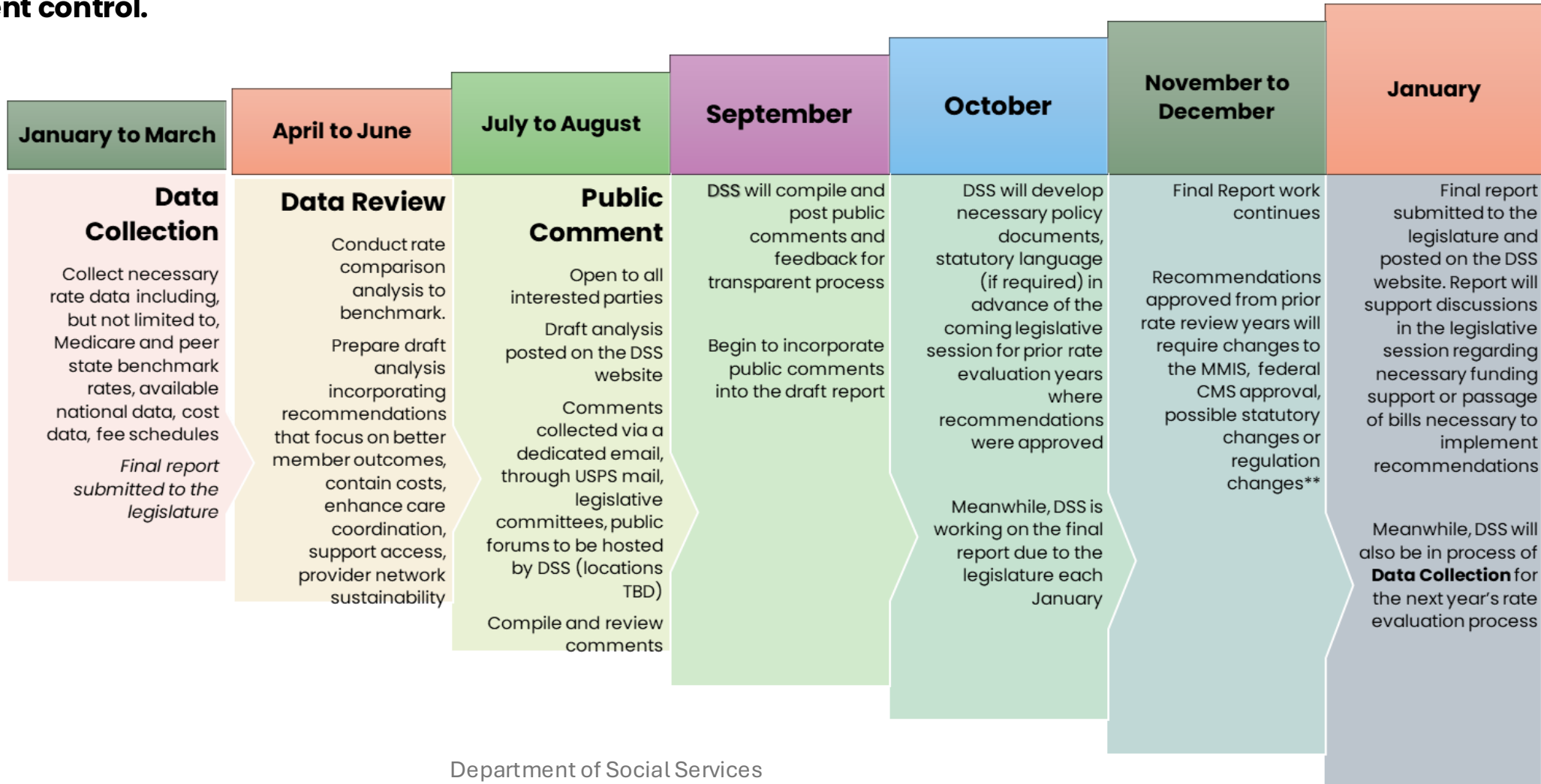


# Medicaid Rate Evaluation Process

- Rate evaluations will take place on a calendar year in accordance with statute.
- Calendar Year aligns with the release of Medicare rate data (released in January).
- Year 1 starts January 2026.
- **Implementation is lengthy, typically taking 12 months or longer, since it is dependent on other factors not within Department control.**

**It is important to note that a comparison to a benchmark does not mean rates are to be automatically increased.**

If data supports a recommendation for a rate increase, such recommendation will need to be reviewed by legislature, OPM and subject to available appropriations. If funding is not immediately available, recommendations may be acted upon in the future when funding is available.



# Rate Evaluation: Year 1

Provider/Fee Schedule	Rate Study Finding	Rate Study Recommendation
<b>Behavioral Health Clinician Psychologist</b>	Rates range from 13% to 164% of five-state benchmark.	Align rates across all behavioral health services closer to the benchmark. Establish rate parity between children and adults.
<b>Independent Radiology</b>	Rates overall compare favorably to the five-state average but are generally lower than Medicare.	Align with Medicare policy and combine fee schedules into one using Medicare as benchmark.
<b>Physician Office and Outpatient</b>	Rates range from 5% to 693% of Medicare.	Consolidate all physician fee schedules into one and rebase using Medicare as the benchmark.
<b>Physician Surgical</b>	Rates range from 21% to 193% of Medicare.	Consolidate all physician fee schedules into one and rebase using Medicare as the benchmark.
<b>Physician Anesthesia</b>	Rates average 63% of Medicare.	Consolidate all physician fee schedules into one and rebase using Medicare as the benchmark.
<b>Physician Radiology</b>	Rates average 77% of Medicare.	Consolidate all physician fee schedules into one and rebase using Medicare as the benchmark.
<b>Acupuncture</b>	Rates average 58% of Medicare and 83% of the five-state average.	Combine fee schedules with Physician for simplification and administrative ease. Rebase to a consistent percentage of Medicare.
<b>Chiropractor</b>	Rates average 52% of Medicare and 87% of the five-state average.	Combine fee schedules with Physician for simplification and administrative ease. Rebase to a consistent percentage of Medicare.
<b>Federally Qualified Health Center</b>	Explore rate increases or Alternative Payment Methodologies (APMs) for quality incentives to tie financial investment to health care outcomes. Note: Rebase using cost year 2023 is in process.	
<b>Home and Community-Based Services (HCBS)</b>	Expenditures are higher than both national average and neighboring states. Note: Department is conducting an analysis of expenditures and utilization, which will be reported at the conclusion of the review.	

# Rate Evaluation: Year 2

Provider/Fee Schedule	Rate Study Finding	Rate Study Recommendation
<b>Clinic - Ambulatory Surgical Center</b>	Rates generally lower than Medicare.	Explore transition to payment methodology under Medicare's outpatient prospective payment system.
<b>Clinic - Medical</b>	Rates generally compare favorably to the five-state average but lower than Medicare.	Use Medicare as the benchmark and develop a consistent timetable for updating rates to a percentage of Medicare.
<b>Clinic - Dialysis</b>	Rates compare favorably with five-state benchmark.	Continue with current approach.
<b>Clinic - Family Planning</b>	Rates compare favorably with both the five-state and Medicare benchmark.	Continue with current approach.
<b>Clinic - Rehabilitation</b>	Rates are on average 96% of Medicare and 135% of the five-state average.	Rebase to a more current Medicare benchmark. Align Independent Physical Therapy and Occupational Therapy, Independent Audiology and Speech and Language Pathology fee schedule with Clinic Rehab fee schedule.
<b>Clinic - Chemical Maintenance</b>	Comparisons could not be made to benchmarks due to the vastly different reimbursement methodologies.	Explore alternative payment methodologies.
<b>Independent Physical and Occupational Therapy</b>	Rates are on average 60% of Medicare and 92% of the five-state average.	Align with Clinic Rehab fee schedule.
<b>Independent Audiology and Speech and Language Pathology</b>	Rates are on average 99% of Medicare and 81% of the five-state average.	Align with Clinic Rehab fee schedule.
<b>Naturopath</b>	Rates are on average 70% of the five-state average; Medicare does not cover.	Rebase rates to a more current benchmark.

# Rate Evaluation: Year 3

Provider/Fee Schedule	Rate Study Finding	Rate Study Recommendation
<b>Transportation – Air Ambulance, Basic / Advanced, Critical Helicopter</b>	Rates were on average 69% of Medicare and 94% of the five-state average but analysis did not factor in the 20% increase to ambulance rates and mileage reimbursement implemented July 1, 2024.	Continue with current approach and develop a timetable for the review and/or update of rates.
<b>Optician / Eyeglasses</b>	Rates are on average 45% of Medicare but 97% of the five-state average.	Rebase to a more current Medicare benchmark and create regularly scheduled updates.
<b>Home Health</b>	Rates are on average 98% of the five-state average.	Develop an independent rate model and evaluate whether the fee schedules should be combined (procedure codes and revenue center codes) and review how services are billed.
<b>Community Living Arrangements</b>	Room & board rate paid by DSS; services paid by DDS	See HCBS portion of the rate study for recommendations for further evaluation of waiver services.
<b>Chronic Disease Hospital</b>	Rates are 86% of comparison states. Rates are currently a per diem, but many states have different methods of reimbursement and different coverage levels depending on each state’s policy goals.	Evaluate and review possible updates to reimbursement methodologies as current per diem is hospital-specific and based on historic cost data that has not been regularly updated.
<b>Residential Care Home (RCH)</b>	Not included in the rate study as rates are outside of Medicaid and paid under the State Supplement program but will be included in the review process.	

# Rate Evaluation: Year 4

Provider	Rate Study Finding	Rate Study Recommendation
<b>MEDS – DME*</b>	For Cures Act codes, rates average 74% of Medicare and 86% of the five-state average; for non-Cures Act codes, rates average 66% of Medicare and 84% of the five-state average.	Consolidate DME fee schedules with Medicare as the benchmark, rebase using a consistent percentage of Medicare.
<b>MEDS – Medical / Surgical Supplies</b>	For Cures Act codes, rates average 72% of Medicare and 106% of the five-state average; for non-Cures Act codes, rates average 75% of Medicare and 90% of the five-state average.	Consolidate DME fee schedules with Medicare as the benchmark, rebase using a consistent percentage of Medicare.
<b>MEDS – Parenteral – Enteral</b>	For Cures Act codes, rates average 92% of Medicare; non-Cures Act codes have no utilization.	Consolidate DME fee schedules with Medicare as the benchmark, rebase using a consistent percentage of Medicare.
<b>MEDS – Prosthetic / Orthotic</b>	Rates average 62% of Medicare and 74% of the five-state average but many codes had no utilization.	Consolidate DME fee schedules with Medicare as the benchmark, rebase using a consistent percentage of Medicare.
<b>MEDS – Hearing Aid / Prosthetic Eye</b>	Rates average 71% of Medicare and 74% of the five-state average.	Consolidate DME fee schedules with Medicare as the benchmark, rebase using a consistent percentage of Medicare.
<b>Dental – Adult &amp; Pediatric</b>	Child: Rates are on average 110% of the five-state benchmark ranging from 6% to 710%. Adult: Rates are on average 118% of the five-state benchmark ranging from 2% to 1313%.	Phase in a single fee schedule for adult and pediatric. Payment parity for dental hygienists. Determine if the Dental fees are consistent with fees on the Physician-Surgery fee schedule. Apply consistent percentages to a benchmark across all codes.
<b>Laboratory</b>	Rates are on average 78% of Medicare but overall compare favorably to the five-state average.	Continue with current approach and develop a timetable for the review and/or update of rates.

\* Federal Cures Act prohibits Medicaid reimbursement for certain DME expenditures that are, in the aggregate, more than what Medicare would have paid.

# Rate Evaluation: Year 5

Provider	Rate Study Finding	Rate Study Recommendation
<b>Nursing Facility</b>	Cost-based per diem adjusted quarterly for acuity. Rates range from about 88% to 92% of the five-state benchmark.	Continue current approach and monitor for coming federal changes under Patient-Driven Payment Model (PDPM) effective July 1, 2026.
<b>Intermediate Care Facility</b>	Cost-based per diem rates are generally above the comparison states' minimum rate, but below maximum, median, average. ICF rates are in the process of a three-year rebase.	Continue with current approach. No recommended action as rates will be fully rebased to 2024 cost year by July 1, 2026.
<b>Autism Spectrum Disorder</b>	Rates are on average 197% of the five-state benchmark, ranging from 62% to 644% with relatively low utilization for certain codes.	Review program for rebalancing of services and shifting of spend to services that support outcomes. Create an independent rate model where rates are built from the ground up using cost components and market factors. Eliminate duplicate codes and update fee schedule with standardized codes for behavioral health therapy.
<b>Psychiatric Residential Treatment Facility</b>	Cost-based per diem. Rates are generally in line with the minimum rate of comparison states, but slightly lower than the maximum, median, and average rates. Rates were increased in 2024 to recognize new costs related to Director of Nursing requirement.	Continue with current approach.
<b>Hospital Outpatient (APC)</b>	Rates are 93% of Medicare (median).	Rebase in accordance with end of hospital settlement agreement. Consider implementation of APMs that include incentives to providers to improve the quality and overall value of services provided to members, including improving cost containment.
<b>Hospital Inpatient (DRG)</b>	Rates compare favorably to the comparison states. Expenditures are 98% of comparison states' expenditures for services that are paid based on DRGs.	Rebase in accordance with end of hospital settlement agreement. Consider implementation of APMs that include incentives to providers to improve the quality and overall value of services provided to members, including improving cost containment.

**Repeat starting with Year 1**

# Medicaid Rate Evaluation Ongoing Developments

- DSS is building on its work to date on the rate evaluation process starting calendar year 2026
- Work continues on the department's dedicated webpage for the rate evaluation process. This page will also serve as a location for public comment and notices: <https://portal.ct.gov/dss/health-and-home-care/reimbursement-and-certificate-of-need/medicaid-rate-study-findings-and-rate-review-process>
- DSS plans to:
  - Proactively utilize MAPOC and existing legislative committees to communicate process to various stakeholders
  - Continue to review fee schedules, consolidating codes when possible

**Note: Any rate change requires CMS approval under the state plan to ensure federal match.**