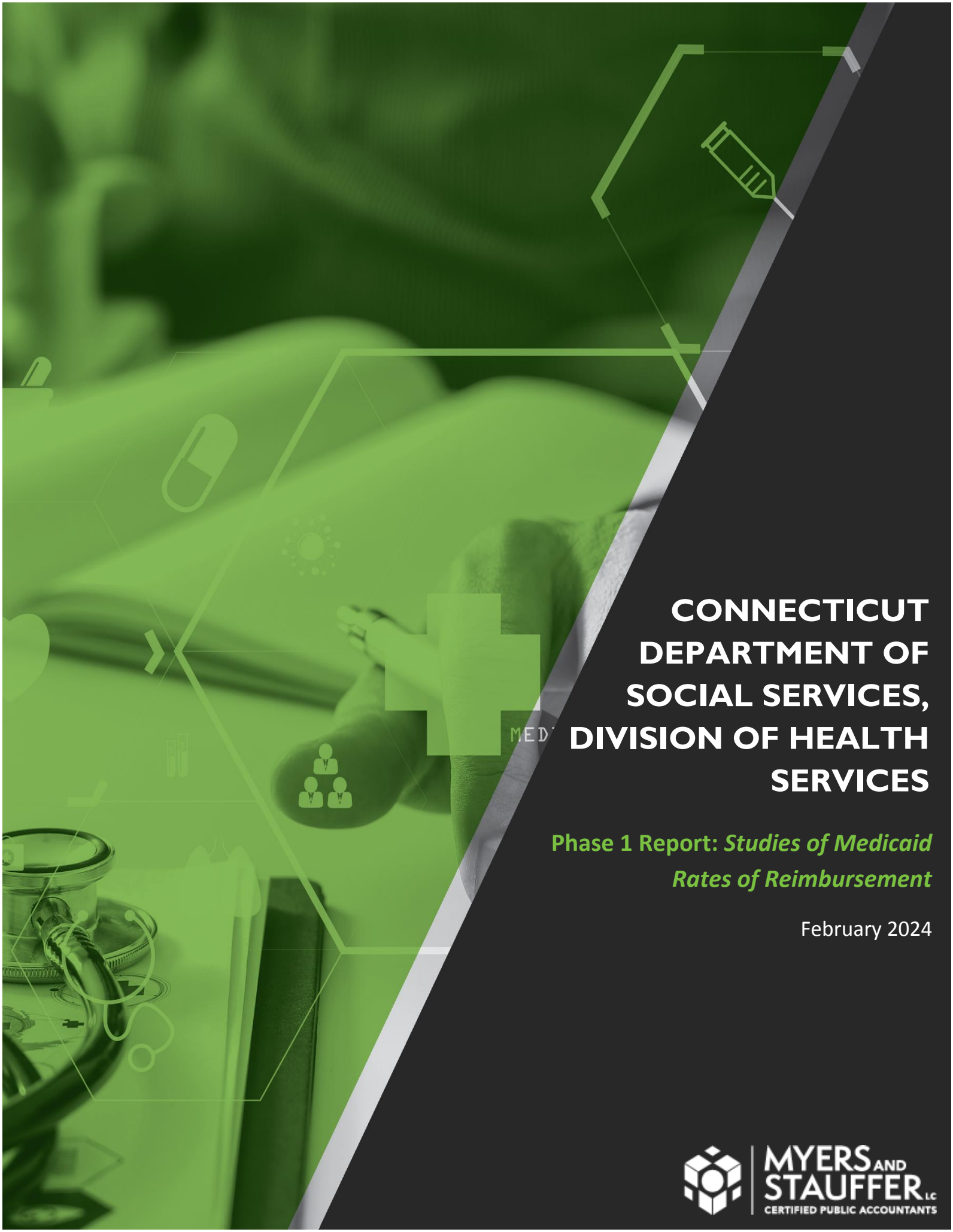

CONNECTICUT DEPARTMENT OF SOCIAL SERVICES, DIVISION OF HEALTH SERVICES

Phase 1 Report: *Studies of Medicaid Rates of Reimbursement*

February 2024

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

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Executive Summary

Connecticut 2023 Senate Bill (SB) No. 989, Public Act No. 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. To conduct this study, the Connecticut Department of Social Services (DSS or Department) has engaged Myers and Stauffer LC (Myers and Stauffer), a firm with longstanding expertise in payment policy and analysis, in support of this work.

The rate study is conducted in two phases: Phase 1 due February 1, 2024, and Phase 2 due January 1, 2025. The goal of phase one, which is the document below, is to review Connecticut Medicaid fee-for-service rates for behavioral health services (BHS)[1], dental services, and physician and other professional services providers, and benchmark Connecticut Medicaid rates to Medicare and peer states. Rate study benchmarking is a vital, data-driven tool used by many state Medicaid programs. Rate studies support Medicaid policy makers in the development of rational rate setting methods that support access to services, and measurable quality outcomes for Medicaid members.

A review of the payment rates for phase 1 services[2] includes recommendations regarding rebasing rates and a timeline. *Figure 1* provides an overall timeline of the project.

Figure 1: Project Timeline

[1] Analysis of the behavioral health codes included all clinic types, however, claims data indicated that the twelve (12) selected codes were only used by the behavioral health clinics. The analysis included is therefore reflective of the services provided by the behavioral health clinics and not medical or rehabilitation clinics.

[2] This group comprises the following fees scheduled: Autism Spectrum Disorder, Behavioral Health Clinicians, Psychologists, Physicians and Outpatient (facility and non-facility), Physicians-Anesthesiology, Physicians-Radiology, Physicians–Surgery (facility and non-facility), Dental-Pediatrics, and Dental-Adult.

Phase 1 rate study results identified areas in the Medicaid fee schedule reimbursement where rates were generally lower. Using this data, the Department has developed recommendations using successful strategies implemented in other state Medicaid programs and is proposing the development of initial recommendations that, when implemented, will meet the Department's goal of rationalizing rates and payment methods, and develop methodological assessments for member access across the program.

The current 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 Department 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 appropriation. Thus, some areas of the Medicaid program have received significantly more frequent or significant rate increases without any evidence-based assessment of sufficiency of rates by service across the entire program. Moreover, 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.

Through this rate study, the Department is now able to systematically identify key fee-for-service reimbursement deficiencies when compared to the applicable benchmarks (all described in detail in the rate study, generally Medicare and peer states' Medicaid rates). Using this data, the Department has developed recommendations using successful strategies implemented in other state Medicaid programs.

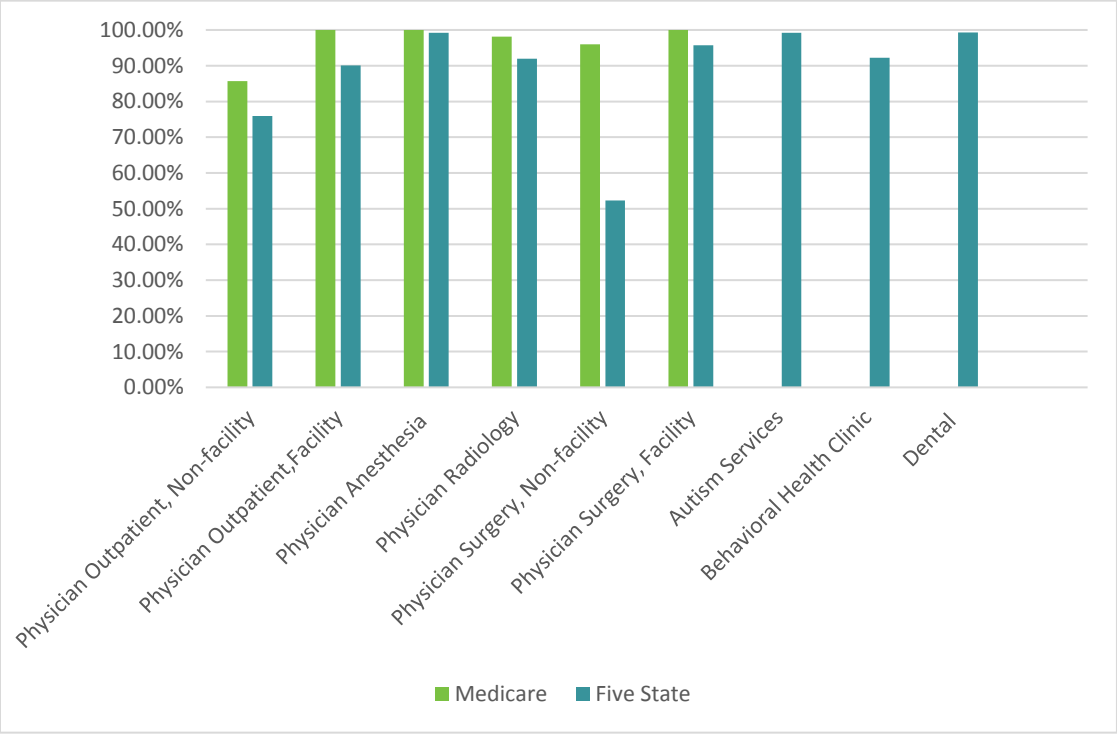
The Department has developed the following key principles based on findings from phase 1 of the rate study and makes the following recommendations:

- The Department will improve upon existing processes to collect and use quantitative and qualitative data regarding Medicaid members' access to care and use that data to support policy decisions designed to improve healthcare access, experience, and outcomes for Medicaid members.
    - This will allow Medicaid to prioritize rate adjustments in response to emerging problems and allow Medicaid to tie payments to providers that perform well on metrics and ensure participants can access quality services economically and efficiently.

Number of Codes Compared

To conduct the rate analysis, Myers and Stauffer was able to identify comparisons for codes representing about 90 percent of Connecticut Medicaid expenditures. In the comparison of Connecticut Medicaid codes and rates to the Five-State Comparison Rate, Myers and Stauffer compared codes representing about 85 percent of expenditures. Since Medicare does not cover dental services, Myers and Stauffer used the Five-State Comparison Rate Codes that were not compared resulted from the lack of matching codes across states, a relatively low number of observations, and other factors detailed in the report. *Figure 2* further identifies the breakout of the codes analyzed within specific fee schedules.

Figure 2: Percent of Expenditures Matched by Fee Schedule



Rate Study Approach

Working with the Department, Myers and Stauffer developed an approach to conduct the rate review that relied on an assessment of the current Connecticut Medicaid methodologies, 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. 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, Centers for Medicare and Medicaid Services (CMS) wage indices, and behavioral health wage comparisons suggest comparability across these states. The states selected for comparison included a selection of five state Medicaid programs for development of a Five-State Medicaid Comparison Rates (i.e., the Five-State Comparison): Maine, Massachusetts, New Jersey, New York, and Oregon. No two Medicaid programs are the same as states can develop their programs uniquely to meet the policy goals of that particular state and its population. To develop a reasonable state comparison, the states selected for the Five State Comparison were of interest due to varying factors because of similar economic indices, and geographic location, states neighboring Connecticut, or had conducted their own Medicaid rate study and were implementing policy and programmatic changes as a result as was the case in Oregon, Maine, and Massachusetts. Selection of the state comparison is only for illustrative purposes and provides contextual information for future discussion regarding potential reimbursement and policy decisions.

More information regarding the Five-State Comparison Rates is found later in this report. More information regarding the Five-State Comparison is found later in this report.

This report compares Connecticut Medicaid rates to Medicare and reported those statistics as benchmarks to use in recalculating, or "rebasing," the rates. The comparison to the programs from other states and Medicare, and the definition of benchmarks, is not intended to suggest fee schedule rates. Instead, the benchmarks provide a standard or point of reference for illustrative purposes only to provide a point of reference against which Connecticut rates may be compared. Benchmarking is a data driven tool that provides the opportunity for Connecticut Medicaid to compare relative payment rates across all provider services, and therefore, should be viewed as a comparison point for illustrative purposes only and is not a recommendation for reimbursement.

State Medicaid programs often use Medicare's rate methods as a baseline, with discretion to make their own adjustments to support the intended goals of the state program. There are important key differences between the Medicare and Medicaid programs' population, structure, and policies, and states must have the ability to independently structure the program to meet the needs of their residents. Many state Medicaid programs use a uniform benchmark percentage of Medicare given Medicare's widely accepted and recognized rate setting process, yet states have limited funds and typically establish fee schedule rates to a percentage of Medicare under the state plan.

The rate study is a tool that can be used to conduct further analysis. The rate study provides a point of reference only. It does not suggest specific fee schedule rate increases or specific Medicaid policy recommendations. Those are decisions needed to be made by the Department and state Medicaid policy makers after additional analysis and engagement with members, providers, and stakeholders. Medicaid rate increases require a legislative budgetary appropriation and federal approval from CMS. By assessing rate adequacy, and rates that are delinked from any rate setting methods, the Department can identify areas for opportunity that support access and quality healthcare outcomes for Connecticut Medicaid members.

Observations

Phase 1 of the rate study revealed a large gap between current fee schedule rates and the benchmark comparisons. Medicaid rate setting should be guided by well operationalized measures of access, quality, economy, and efficiency. In accordance with federal law, Section 1902(a)(30(a) of the Social Security Act, Medicaid programs must establish criteria for reimbursement policy that provides Medicaid members with access to services 'while promoting efficiency, quality, and economy'. These broad concepts support states in the ability to develop measurable outcomes for member services.

There is no specific federal guidance from CMS regarding how states should benchmark their rates or at what percentage. States have discretion in the development of their own reimbursement methodologies

and can select a benchmark percentage for reimbursement within available state appropriations. This report uses 80 percent of Medicare benchmark for illustrative purposes only. It is not meant to be a recommendation but a basis for comparison. Using this benchmark in comparing Connecticut Medicaid rates to Medicare rates and the Five-State Comparison provided additional information to support the rate study, as follows.

- *Behavioral Health Services[3] and most physician and outpatient services (including anesthesia, radiology, and surgery), rates are generally lower than the Five-State Comparison Rates and Medicare, although rates for HUSKY Primary Care services are on average higher than comparison rates for other services.*
- *Individual rates for autism spectrum disorder (ASD) services are on average higher than comparison rates for other services, but this occurs primarily because of an extremely high rate for one service and the relatively low number of codes available for comparison.*
- *Dental Fee Schedule rates for adults and pediatrics are generally higher than the Five-State Comparison Rates.*
- *Connecticut rates have not been updated over the years when compared to Medicare for Physician-Outpatient, Physician-Anesthesia, Physician-Radiology, and Physician-Surgery fees. All rates were set at the same percentage of Medicare when the fee schedules were implemented, but the comparison percentages have changed over the years as Medicare has updated rates annually and Connecticut Medicaid has not.*

In addition to the development of comparison metrics for the various fee schedules, a review of current Connecticut Medicaid fee schedule policies, Medicare regulations regarding payment methodologies, and the methodologies of the five comparison states[4] was conducted. This review of methodologies provided additional information to support the rate study, as follows.

- *Phase 1 services fee schedules that are based on well-established and documented methodologies are: the Physician and Outpatient, HUSKY Health Primary Care Physician Anesthesia, Radiology, and Surgery Fee Schedules are all based on the Medicare Physician Fee Schedule.*
- *Outside of the above-mentioned fee schedules, the other fee scheduled examined in Phase 1 are based on historical methodologies and calculations that have not been updated since implementation. For some fee schedules, rates have not been updated in over 10 years.*

[3] Analysis of the behavioral health codes included all clinic types, however, claims data indicated that the twelve (12) selected codes were only used by the behavioral health clinics. The analysis included is therefore reflective of the services provided by the behavioral health clinics and not medical or rehabilitation clinics.

[4] Appendix A provides data sources, and a summary of the review of the CT and other states' methodologies.

- *The Dental Fee Schedule (Adult and Pediatric) was established in 2004 using approximately 60 percent of the 50th percentile of dentists' charges in Connecticut. DSS now uses a database of Connecticut dentists' charges to develop rates for new codes as they are introduced, but it is not clear how the 2004 source was derived or how it compares to the database of charges now in use to price new codes.*
- *The fee schedule methodologies for BHS and ASD services are based on historical data.*
- *None of the methodologies reviewed in Phase 1 include a provision for regular review and/or updating of rates.*
- *Connecticut Medicaid's approaches to service definition and use of coding systems for some services is not always consistent with those of the comparison state Medicaid programs. Some of the differences are explained by the different approaches that states use to deliver services, in particular for BHS and ASD services. It is not clear why there are other differences; for example, within the dental services area, DSS uses both Current Procedural Terminology (CPT)[5] and Current Dental Terminology (CDT) codes. The Connecticut approach is in contrast to the methodologies of the comparison states that rely primarily on CDT codes (except for oral surgery, some radiology, and office visits).[6] Myers and Stauffer also found instances in the Connecticut fee schedule where comparable services have different codes and are on different fee schedules.*

Recommendations Regarding Updating Fee Schedules

The benchmarks in this report serve as comparison points and are not final recommendations for reimbursement. Myers and Stauffer developed one approach to establish comparisons that relies on using the Medicare fee schedule where code comparisons were possible and, if not, the Five-State Comparison Rate. The study compares dental services to the Five-State Comparison Rate. For dental services, the comparison of fees to the Five-State Comparison Rate indicates that fees for adult services are, on average, are lower than pediatric services, and comparison rates vary considerably from service to service. On average, both the Adult and Pediatric dental rates are higher than the Five-State Comparison Rate but

[5] The CPT descriptive terminology and associated code numbers provide the most widely accepted medical nomenclature used to report medical procedures and services for processing claims, conducting research, evaluating healthcare utilization, and developing medical guidelines and other forms of healthcare documentation. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3865623/#:~:text=The%20CPT%20descriptive%20terminology%20and,other%20forms%20of%20healthcare%20documentation

[6] The CDT code set is maintained by the American Dental Association and consists of procedural codes for oral health and adjunctive services provided in dentistry. According to the ADA, where insurance is involved, the standard practice is to submit a claim first to the dental insurance plan and if denied and covered under a medical benefit, to then bill the health insurance plan with CPT. CPT is maintained by the American Medical Association and used to report medical procedures.
6 The five state Medicaid programs use CDT for their dental fee schedules, and CPT for oral surgery. Source: *https://www.ada.org/resources/practice/dental-insurance/frequently-asked-questions-regarding-dental-codes*.

there are codes well below and above the Five-State Comparison Rate for both adult and pediatric dental services.

Figure 3 illustrates that under this approach, a total of $760.2 million would be benchmarked, broken out as follows: $436 million using the Medicare benchmark, $264.5 million using the Five-State Comparison Rate Benchmark. Remaining expenditures that could not be matched were $59.7 million. Medicare does not cover the state specific HCPCS behavioral health services, autism or dental and therefore, a comparison to the five states is most appropriate for these services.

Figure 3: Expenditures by Benchmark Used (in $ Millions)

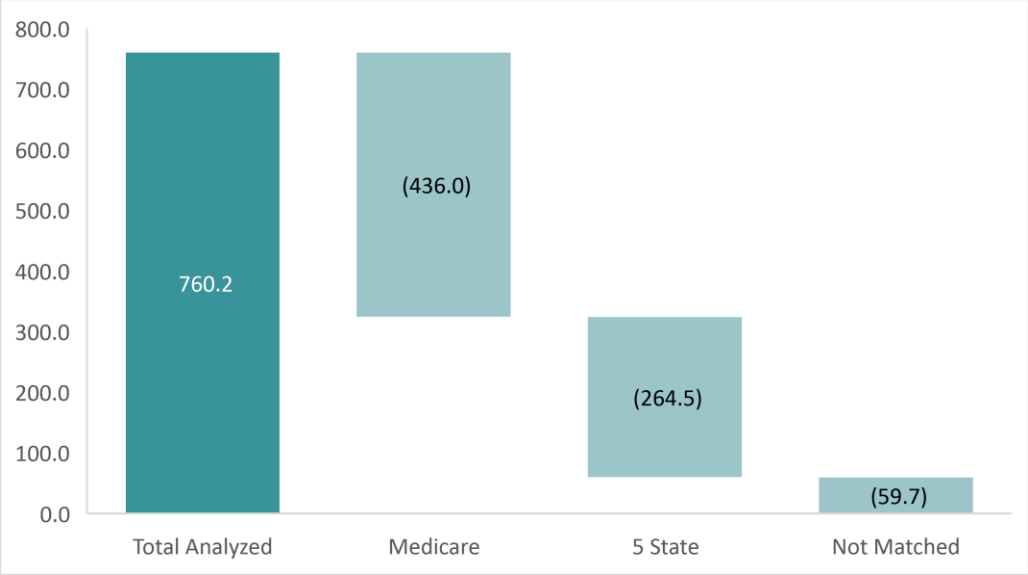


Table 1: Benchmark Summary Analysis

Fee Schedule	Benchmark Summary Analysis $ in Millions Current Expenditures	80% Medicare	100% Five- State Comparison	Expenditures Associated with Non-Matched Codes	Total Expenditures at Benchmark	Percent Change (Current Expenditures vs At Benchmark)
Physician – Outpatient						
• Non-facility	312.0	373.2		51	438.8	40.6%
• Facility[7]	22.7	30.4		0.0	30.4	33.9%
Physician - Anesthesia	16.8	21.1		0.0	21.1	25.6%
Physician - Radiology	45.6	45.7		0.9	46.9	2.9%
Physician - Surgery						
• Non-facility	77.8	102.7		3.2	107.3	37.9%
• Facility	16.2	21.3		0.0	21.3	31.5%
Autism Services	51.0		65.0	0.3	65.5	28.4%
Behavioral Health Clinic	39.1		81.4	3.4	88.5	126.3%
Dental	179.0		177.4	0.9	178.4	(0.3)%
Total	**760.2**	**594.4**	**323.8**	**59.7**	**998.2**	**31.3%**

[7] 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.

As indicated in *Table 1* if rates for all services were increased to the benchmarks, expenditures would increase 31.3 percent. The greatest increase would be 126.3 percent increase for BHS from the current expenditures to the benchmark; dental services would experience a slight decrease of 0.3% from current expenditure to the Five-State Comparison benchmark.

The recommendations presented above are made without consideration of funding levels. Given the reality of determining how to allocate resources for a rate increase, Myers and Stauffer created a number of scenarios for DSS' consideration, as follows.

A. Increase rates to a specified percentage of the benchmark. In this scenario, a fixed percentage of the benchmark would be selected and the fee schedules of all providers below that benchmark would be increased to the specified percentage. However, providers with fee schedules that are currently above the benchmark would not experience a change to their rates.

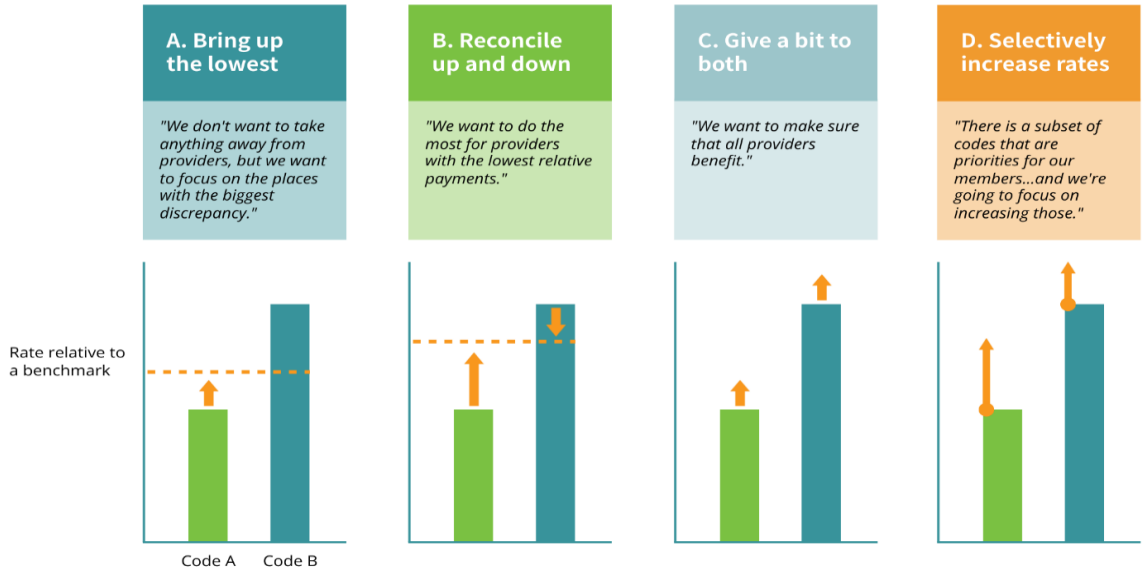
B. Increase rates to a specified percentage of the benchmark; rebalance rates so all codes are paid at the same percentage of the benchmark. In this scenario, providers with fee schedules under the benchmark experience an increase, while those with fee schedule rates higher than the benchmark would experience a decrease in those rates.

C. Phase in rate increases (i.e., increase the fee for every code) with the objective of increasing rates for all codes within a fee schedule to the benchmark. In this scenario, all providers would see a small percentage increase, but it would not be relative to a benchmarked rate.

D. Target rate increases to codes for which there are known access and quality issues. In this scenario, increases would be targeted to specific services or service areas where the rates are below the benchmark and where there are clear policy reasons for directing a targeted increase to benefit the health and well-being of the population.

The scenarios described above are further illustrated in Figure 4 below.

Figure 4: Rate Rebasing Scenarios



While each scenario is described separately, it would be possible to implement some combination of the four. For example, providers could be brought up to a percentage of the benchmarked rate overall, while a select group of services could be targeted for an additional increase to overcome an access barrier.

To model potential impact of rate adjustments to the benchmark, Myers and Stauffer used 80 percent of Medicare as the Medicare benchmark as a point for comparison.[8] 100 percent of the Five-State Comparison Rate was used for those services where Medicare rates are not present to demonstrate how the various options can be applied. To provide additional context, the Five-State Comparison Rate is 68.8 percent of the Medicare rate for codes that are present in both analyses.

When modeling potential financial impact of rate adjustments, there are generally two methods that can be used. The first method is where any rate that is below the benchmark rate is increased, but rates above the benchmark remain the same and are not adjusted downward. The second method increases all rates up to the benchmark and decreases any rates downward to the benchmark. To model this, Myers and Stauffer calculated the increase/decrease using both methods.

- Autism Services would have an estimated additional cost of $14.5 million if only increasing rates below the benchmark and would have an overall net increase of $13.9 million if increasing rates below the benchmark while decreasing rates above.

[8] https://www.cms.gov/newsroom/fact-sheets/summary-medicaid-and-chip-payment-related-provisions-ensuring-access-medicaid-services-cms-2442-p

- Behavioral Health Clinic would have an estimated additional cost of $49.4 million if only increasing rates below the benchmark and would have a net increase by $48.4 million if increasing rates below the benchmark while decreasing rates above.
- Dental currently utilizes two fee schedules (adult and pediatric). This analysis assumes that adopting a benchmark fee schedule would condense the fee schedules into one which could result in some individual rates going up or down. In that scenario there would be no additional cost for increasing rates to the benchmark, but there would be a net reduction of $4.1 million for increasing rates below the benchmark and decreasing rates above.
- Physician-Anesthesia would have an estimated additional cost of $4.3 million if only increasing rates below the benchmark. There is a very small reduction of approximately 1% resulting in a net increase of $4.27 million for increasing rates below the benchmark and decreasing rates above.
- Physician-Radiology would have an estimated additional cost of $7.8 million if only increasing rates below the benchmark, and a net increase of $4.7 million if increasing rates below the benchmark and decreasing rates above.
- Physician-Surgery Facility would have an estimated additional cost of $4.8 million if only increasing rates, and a net increase of $4.4 million if increasing rates below the benchmark and decreasing rates above.
- Physician Surgery Non-Facility would have an estimated additional cost of $22.0 million if only increasing rates, and a net increase of $16.0 million if increasing the rates below the benchmark and decreasing rates above.
- Physician Outpatient Facility would have an estimated additional cost of $6.2 million if only increasing rates, and a net increase of $4.9 million if increasing rates below the benchmark and decreasing rates above.
- Physician Outpatient Non-Facility would have an estimated additional cost of $82.4 million if only increasing rates, and a net increase of $48.6 million if increasing rates below the benchmark and decreasing rates above.

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 makes the following recommendations:

- *Review rates using the Medicare fee schedule for services with a methodology based on a percent of Medicare. A fixed percentage of Medicare (the "Medicare benchmark") would be selected and the fee schedules of all providers below that benchmark would be reviewed for recommended adjustments in accordance with available appropriations. The rate review would also identify codes that are 'delinked' from Medicare and benchmarking would be brought under the same benchmarking policy as all other codes on the same fee schedule. This framework is necessary to ensure members have continued ongoing access to critical services.*

- *Make rate adjustments for Autism Spectrum Disorder Services. Using the Five-State Comparison Rates, review current reimbursement policy and model where rates are built from the ground up and based on the sum of independently determined cost components and market factors. Consider provider education levels and develop new service definitions to standardize payment rates as part of the rebasing.*
- *Increase BHS rates in a two-step process to improve equity across Phase 1 service providers. First, increase rates up to a percent of the Five-State Comparison Rate. Next, within 2-3 years, adjust rates using an independent rate model where rates are built from the ground up and based on the sum of independently determined cost components and market factors, and within available appropriations. Consider provider education levels and develop new service definitions to standardize payment rates as part of the rebasing.*
- *Resolve inconsistencies in reporting and defining services across the various fee schedules for ASD, BHS, and Dental services.*
- *Determine if policies related to paying providers should be changed to improve access to services where gaps are identified, as is done in some of the comparison states.*
- *Target rate adjustments to codes for which there are known access and quality issues. Adjustments would be targeted to specific services or service areas where there are clear policy reasons for directing a targeted rate adjustments to benefit the health and well-being of members.*

The remainder of this report provides detailed information about the work Myers and Stauffer performed and the comparison of each fee schedule to the Medicare, and Five-State Comparison, as applicable.

Comparison of Fee Schedules

Selected Services

For Phase 1, Myers and Stauffer reviewed fee schedules for the following providers/services as illustrated in *Table 2*.

Table 2: Phase 1 Services and Fee Schedules

Phase 1 Services and Fee Schedules	
Providers/Services	**Fee Schedule Name**
Behavioral Health[9]	• Autism Spectrum Disorder (ASD) • Behavioral Health Clinician • Clinic Medical – select services • Clinic Rehabilitation – select services • Psychologist
Dental Services	• Dental Adult • Dental Pediatric
Physician Specialists	• Physician Office and Outpatient Services (excludes physician-administered drugs) • HUSKY Health Primary Care • Physician Anesthesia • Physician Radiology • Physician Surgical

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 these 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 not intended to fully represent all the nuances of the individual rate setting processes.

Approach

Working with the Department, Myers and Stauffer selected five state Medicaid programs for comparison of Medicaid fee schedules to Connecticut's fee schedules. 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

[9] Analysis of the behavioral health codes included all clinic types, however, claims data indicated that the twelve (12) selected codes were only used by the behavioral health clinics. The analysis included is therefore reflective of the services provided by the behavioral health clinics and not medical or rehabilitation clinics.

states. The selected states were Maine, Massachusetts, New Jersey, New York, and Oregon. 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; the Department selected Oregon as an additional state for review because it has adopted a number of VBP programs and alternative payment methods that provide insight into innovative payment program design. Since no two Medicaid programs are the same as states can develop their programs uniquely to meet the policy goals of that particular state and its population, to develop a reasonable state comparison, the states selected for the Five State Comparison were of interest due to varying factors because of similar economic indices, and geographic location, states neighboring Connecticut, or had conducted their own Medicaid rate study and were implementing policy and programmatic changes as a result as was the case in Oregon, Maine, and Massachusetts. Selection of the state comparison is only for illustrative purposes and provides contextual information for future discussion regarding potential reimbursement and policy decisions. *Table 3* provides a summary of the key variables considered in the selection of the comparison states.

Table 3: State Comparison Variables

State Comparison Variables						
	Connecticut	**Maine**	**Massachusetts**	**New Jersey**	**New York**	**Oregon**
Number of Medicaid Enrollees[10]	994,340	360,187	1,820,904	1,997,293	7,031,633	1,229,514
Risk Based Managed Care	N	N	Y	Y	Y	Y
Average Resource-Based Relative Value Scale (RBRVS) Geographic Practice Indices (above 1)[11,12]	Y	N	Y	Y	Y	N
Average/Median CMS Wage Indices[13]	1.1287/ 1.1232	0.9634/ 0.9395	1.0663/ 1.0488	1.0450/ 1.0429	0.9620/ 0.9501	1.1153/ 1.1118

[10] May 2023 Medicaid Enrollment: https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html

[11] Medicare PFS relative value units are multiplied by a geographic practice cost index (GPCI). The information presented here is for the combination of the three components of the RVU. Source: https://www.cms.gov/medicare/physician-fee-schedule/search/documentation#:~:text=A%20geographic%20practice%20cost%20index, practice%20expense%2C%20and%20malpractice).

[12] We averaged Physician Work, Practice Expense and Malpractice GPCIs to determine if the average is greater than 1.0. Massachusetts, Maine, New Jersey, New York and Oregon have GPCIs for separate localities, so we averaged GPCIs for each locality in a state to determine a state average Physician Work, Practice Expense, and Malpractice GPCI. https://emds.com/gpci/

[13] The ratio of the area's average hourly wage to the national average hourly wage. CMS uses the wage index to adjust national standard payment amounts for each geographic area where a hospital is located. We calculated an average and a median wage value for comparison purposes to take into account that some states have multiple wage index factors. https://www.cms.gov/medicare/medicare-fee-service-payment/acuteinpatientpps/wage-index-files/fy2023-wage-index-home-page

State Comparison Variables						
	Connecticut	Maine	Massachusetts	New Jersey	New York	Oregon
Cost of Living Index[14]	114.4	112.5	143.1	104.3	126.6	116.2
Adult Dental Coverage[15]	1	1	1	1	1	1
Wage Comparisons for Behavioral Health Professionals[16]	2	6	5	1	3	4
FMAP %[17]	50	62.65	50	50	50	59.31

Myers and Stauffer also compared Medicaid rates to Medicare rates (national rates adjusted for Connecticut). Medicare often serves as the comparison point for states when evaluating their payment methodologies and rates.

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. State legislation determines Medicaid agency budgets based on state revenues, and appropriations are authorized by the legislature and provide agencies with authority to expend funds. Therefore, state agencies are limited in amounts for reimbursement rates based on state budgets. In addition, the federal government's share of

[14] The Council for Community and Economic Research summarizes cost of living data based on voluntary survey participants. The index takes into account costs of groceries, housing, utilities, transportation, health, and miscellaneous expenses. https://meric.mo.gov/data/cost-living-data-series

[15] https://www.milliman.com/-/media/milliman/importedfiles/ektron/medicaid-adult-dental-reimbursement.ashx; a "1" indicates extensive, a "2," emergency only.

[16] We scored each state's hourly median wage for nine BHS occupations with a score from 1 (highest hourly median wage) to 12 (lowest hourly median wage) and then totaled scores for each state to determine the ranking shown here; "1" indicates the highest hourly median wages for behavioral health occupations and "12" indicates the lowest hourly median wages for behavioral health occupations. https://www.bls.gov/oes/special-requests/oesm22st.zip

[17] The FMAP is computed from a formula that takes into account the average per capita income for each state relative to the national average. Source: https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

a state's expenditures through 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.

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

Overall Findings Related to the Fee Comparisons

Rate comparisons provided in the tables throughout this section provide information regarding the comparison of Connecticut Medicaid rates to benchmarks, identified as the Five-State Medicaid comparison and the Medicare comparison. Myers and Stauffer provide comparisons regarding Connecticut Medicaid rates to the average of the five states and to the Medicare rate, and the range of comparison percentages across codes. Myers and Stauffer also provided the number of unique codes included in the comparisons.[18] The analyses of the comparisons to the five state Medicaid rate averages, show the number of codes where rates are above and below the benchmarks. Myers and Stauffer also conducted an analysis of current expenditures based on claims data, and benchmarked expenditures on what Connecticut Medicaid would pay if it applied the Five-State Comparison benchmark and the Medicare benchmark, and the percentage difference.[19] The expenditure information shows the cost of rebasing at the benchmark values. As Connecticut Medicaid increases or decreases the benchmark, the rebasing impacts will change. The following tables present the results of the rate comparisons for each of the select services.

Autism Spectrum Disorder

[18] 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.
[19] Expenditures shown are less than actual Connecticut Medicaid expenditures since some claims were not included in the analysis because of data limitations. Appendix A provides information regarding the use of claims data to determine expenditures.

After removing codes for services with no match to other states' data, Myers and Stauffer reviewed nine codes and rates for ASD services in the Connecticut Medicaid program, as shown in *Table* 4: Summary of ASD Fee Comparison

4, and compared the rates to Medicaid programs in the states of Maine, Massachusetts, New Jersey, New York, and Oregon. Medicare does not provide coverage of ASD services.

Table 4: Summary of ASD Fee Comparison

Summary of ASD Fee Comparison	
	CT Compared to Five-State Average
	Non-Facility
Comparison Rate Percentage Range	61.7%-644.2%
Average Comparison Rate Percentage	196.8%
Average Comparison Rate for Diagnostic Services	295.4%
Average Comparison Rate for Treatment Services	73.5%
Count of Distinct Codes	9
Percentage of CT Codes Below the Comparison Rate	55.6%
75-99% of the Comparison Rate	22.2%
50-74% of the Comparison Rate	33.3%
25-49% of the Comparison Rate	0.0%
0-24% of the Comparison Rate	0.00%
Percentage of CT Codes Above the Comparison Rate	44.4%
0-124% Above the Comparison Rate	11.1%
125-149% Above the Comparison Rate	0.0%
150-174% Above the Comparison Rate	0.0%
175-199% Above the Comparison Rate	0.0%
200% or More Above the Comparison Rate	33.3%
Estimated Current Expenditures	**$50,856,826**
Amount Excluded (No Match)	**$358,414**
Estimated expenditures at Five-State Benchmark	**$64,752,318**
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	**$13,895,492**
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	**27.3%**

The relatively small number of codes compared for ASD services should be taken into account when reviewing these findings. The analysis of nine codes, however, includes the review of the most frequently occurring code, 90791: "integrated biopsychosocial assessment, including history, mental status, and recommendations" with modifier U5 to denote ASD services. Myers and Stauffer also separated the

diagnostic codes from the treatment codes, as the small number of codes and the variance between the two categories skewed the average comparison rate.

- *Connecticut ASD rates average 196.8 percent of the Five-State Comparison Rate. ASD rates range from 61.7 to 644.2 percent of the Five-State Comparison Rate. However, the average comparison rate for diagnostic services by themselves was 295.4 percent. The average comparison rate for treatment services was 73.5 percent.*
- *The relatively low volume for certain codes is a consideration in evaluating this analysis. For example, the comparison rate for 90791 (U5, 22 [increased procedural services]) was 644 percent, but this code represents only 523 units of service. There were more than 3 million units of code 97153: adaptive behavior treatment by protocol, with a comparison rate of 76 percent. In all, Connecticut Medicaid spent $2,043,273 for diagnostic services and $48,704,423 for treatment services. Of the rates for nine codes, four are above and five are below the comparison rate.*
- *For those codes below the comparison rate, two codes are 75 to 99 percent of the comparison rate and three codes are 50 to 74 percent.*
- *Of the codes above, one was 0 to 124 percent above, and three were 200 percent or more above the comparison rate.*

Behavioral Health Services (Behavioral Health Clinician, Clinic-Medical, Clinic-Rehabilitation, Psychologist)

After removing from the analysis codes that could not be matched with those of other states, Myers and Stauffer reviewed 12 codes and rates for BHS in the Connecticut Medicaid program and compared the rates to Medicaid programs in the states of Maine, Massachusetts, New Jersey, New York, and Oregon. Analysis of the behavioral health codes included all clinic types, however, claims data indicated that the twelve (12) selected codes were only used by the behavioral health clinics. The analysis included is therefore reflective of the services provided by the behavioral health clinics and not medical or rehabilitation clinics. Codes such as those on the Psychologist Fee Schedule (PFS) that use CPT were included in the PFS and compared to the Five-State Comparison and Medicare. Codes that are state-specific and use the Healthcare Common Procedure Coding System (HCPCS) were not compared to Medicare, as Medicare does not provide coverage of these state-specific services in a comparable way. BHS procedure codes not captured in the Physician Fee benchmarking analysis were selected for comparison with similar Maine, Massachusetts, New Jersey, New York, and Oregon procedure codes. Codes for BHS were gathered from several fee schedules including Psychologist, Behavioral Health Clinician, Clinic-Medical, and Clinic-Rehabilitation. Codes that appeared on these schedules that were not considered BHS were not included in this phase of the study. The codes included in this analysis include only the HCPCS codes; CPT codes for visits and other services are analyzed with the Physician and Outpatient Fee Schedule(s).

Table 5: Summary of Behavioral Health Services Fee Comparison

Summary of Behavioral Health Services Fee Comparison	
	CT Compared to Five-State Average
Comparison Rate Percentage Range	13.3%-163.6%
Average Comparison Rate Percentage	62.3%
Count of Distinct Codes	12
Percentage of CT Codes Below the Comparison Rate	91.7%
75-99% of the Comparison Rate	33.3%
50-74 of the Comparison Rate	16.7%
25-49% of the Comparison Rate	16.7%
0-24% of the Comparison Rate	25.0%
Percentage of CT Codes Above the Five-State Comparison Rate	8.3%
More than 200% Above the Comparison Rate	0.0%
0-124% Above the Comparison Rate	0.0%
125-149% Above the Comparison Rate	0.0%
150-174% Above the Comparison Rate	8.3%
175-199% Above the Comparison Rate	0.0%
200% or More Above the Comparison Rate	0.0%
Estimated Current Expenditures	**$39,083,713**
Amount Excluded (No Match)	**$3,398,380**
Estimated Expenditures at Five-State Benchmark	**$81,484,425**
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	**$42,400,712**
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	**108.5%**

The number of BHS codes available for review was also relatively small. Myers and Stauffer could make valid rate comparisons for only 12 of the 17 distinct HCPCS codes. The estimated financial impact was calculated based on the 12 codes; however, those 12 codes comprised 92.8 percent of the selected BHS expenditures and claims data indicated that the twelve (12) selected codes were only used by the behavioral health clinics.

When an equitable comparison was able to be made the data indicates:

- *Connecticut Medicaid rates for BHS average 62.3 percent of the Five-State Comparison Rate. Rates ranged from 13.3 to 163.6 percent of the Five-State Comparison Rate. 91.7 percent of the Connecticut rates for these services are below the Five-State Comparison Rate.*

- *Of the Connecticut rates, 8.3 percent of rates for these services are above the Five-State Comparison Rate, with no rates more than 175 percent above the Five-State Comparison Rate.*
- *If current Connecticut rates were increased to at least 100 percent of the Five-State Comparison Rate, it would cost 208.5 percent of the current spend on these services (assuming volume and mix of services stays the same). Estimated current expenditures using this benchmark are $81,484,425, which would be a $42,400,712 increase over the current spend of $39,083,713.*

As stated above, the majority of the codes on the Psychologist fee schedule were included in the PFS. However, there are a few notable observations about the rate comparisons for those specific CPT codes.

- *An analysis of 52 codes showed Connecticut rates are, on average, 71.6 percent of the comparable Medicare rates and 109 percent of the Five-State Comparison Rates.*
- *Like many other BHS codes, some of the Psychologist codes were not covered in all five states or by Medicare (e.g., 90875, which was only present in the fee schedule in two states).*

The lack of comparison data for behavioral health is not unexpected; making state-to-state comparisons of rates for behavioral health services is difficult because states generally develop service definitions and procedure codes for those services based on how services are delivered locally. However, as new services are developed, it is recommended that Connecticut develop a practice to review and remove old unused codes or update them to reflect current changes in billing practices.

Dental (Adult and Pediatric)

Myers and Stauffer reviewed 174 codes in the adult fee schedule, and 186 codes in the pediatric fee schedule. Rates were compared to Medicaid programs in the states of Maine, Massachusetts, New Jersey, New York, and Oregon as shown in *Table 6*. The number of available codes for review was dependent upon payers' listing of those codes on their fee schedules. Because Medicare does not provide coverage of dental services, rates were compared to the Five-State Comparison Rates.

Table 6: Summary of Dental Services Fee Comparison

	CT Compared to 5-State Average Adult Rates	CT Compared to 5-State Average Pediatric Rates
Comparison Rate Percentage Range	2.4%-1312.5%	6.3%-710.1%
Average Comparison Rate Percentage	117.7%	109.9%
Count of Distinct Codes	179	191
Percentage of CT Codes Below the Comparison Rate	46.9%	40.8%

	CT Compared to 5-State Average Adult Rates	CT Compared to 5-State Average Pediatric Rates
75-99% of the Comparison Rate	24.0%	13.1%
50-74% of the Comparison Rate	14.5%	14.7%
25-49% of the Comparison Rate	6.7%	11.0%
0-24% of the Comparison Rate	1.7%	2.1%
More than 200% Below the Comparison Rate	46.9%	0.0%
Percentage of CT Codes Above the Comparison Rate	53.1%	59.2%
0-124% Above the Comparison Rate	27.9%	22.6%
125-149% Above the Comparison Rate	11.7%	21.5%
150- 174% Above the Comparison Rate	6.2%	6.3%
175-199% Above the Comparison Rate	5.1%	5.8%
200% or More Above the Comparison Rate	2.2%	3.1%
Current Estimated Expenditures	**$128,605,083**	**$211,629,087**
Estimated Expenditures At Five-State Benchmark	**$151,984,703**	**$192,384,959**
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	**$23,379,621**	**$19,244,128**
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	**18.2%**	**9.1%**

Key points from these comparisons include the following.

- *Connecticut Medicaid rates for dental services average 117.7 percent of the Five-State Comparison Rate for the adult fee schedule and 109.9 percent of the Five-State Comparison Rate for the pediatric fee schedule. Rates range from 2.4 to 1312.5 percent of the Five-State Comparison Rate for adult dental services and 6.3 to 710.1 percent of the Five-State Comparison Rate for pediatric dental services.*
- *46.9 percent of the Connecticut Medicaid adult dental rates for these services are below the Five-State Comparison Rate, with 6.7 percent less than 50 percent of the Five-State Comparison Rate. 40.8 percent of the Connecticut Medicaid pediatric dental rates for these services are below the Five-State Comparison Rate, with 11.0 percent less than 50 percent of the Five-State Comparison Rate.*
- *53.1 percent of the Connecticut Medicaid adult dental rates for these services are above the Five-State Comparison Rate, with 11.7 percent less than 150 percent above the Five-State Comparison Rate. 59.2 percent of the Connecticut Medicaid pediatric dental rates for these services are above the Five-State Comparison Rate, with 3.1 percent 200 or more percent above the Five-State Comparison Rate.*

- *If Connecticut Medicaid paid adult dental services at 100 percent of the Five-State Comparison Rate, there would be an estimated increase of $23,379,621, or 18.2 percent of current estimated expenditures, assuming volume and mix of services stays the same.*
- *If Connecticut Medicaid paid services at 100 percent of the Five-State Comparison Rate for pediatric services, there would be an estimated decrease of $19,244,128, or 9.1 percent, of current estimated expenditures, assuming volume and mix of services stays the same.*

Physician Office and Outpatient Services and HUSKY Health Primary Care (Non-Facility)

Myers and Stauffer reviewed 1,635 (non-facility) and 221 facility codes/rates for physician office and outpatient services provided by the Connecticut Medicaid program and compared the rates to Medicaid programs in the states of Maine, Massachusetts, New Jersey, New York, and Oregon. A similar number of codes were compared to Medicare and 1,649 non-facility and 228 facility codes were compared to Connecticut Medicaid.

It was not possible to classify units of service to either the HUSKY Health Primary Care fee schedule or the Physician and Outpatient Fee Schedule in the claims data base. Comparisons in *Table 7* consider all the codes in the Physician and Outpatient Analysis with the rates associated with that fee schedule.

Table 7: Summary of Physician Outpatient Fee Comparison

Summary of Physician Outpatient Fee Comparison				
	CT Compared to 5-State Average		CT Compared to Medicare	
	Non-Facility[1]	Facility[2]	Non-Facility[3]	Facility[4]
Comparison Rate Percentage Range	30%-151.1%	4.6%-152.7%	4.7%-693.1%	13.6%-142.1%
Average Comparison Rate Percentage	89.2%	71.7%	65.3%	60.7%
Count of Distinct Codes	1635	221	1649	228
Percentage of CT Codes Below the Comparison Rate	70.3%	84.6%	90.5%	95.2%
76-99% of the Comparison Rate	45.6%	29.0%	13.0%	7.0%
51-75% of the Comparison Rate	18.4%	32.6%	46.3%	67.1%
25-490% of the Comparison Rate	6.4%	19.0%	24.9%	20.2%
0-24% of the Comparison Rate	0.0%	4.1%	6.3%	0.9%
Percentage of CT Codes Above the Comparison Rate	29.7%	15.4%	7.3%	4.8%
0-124% Above the Comparison Rate	21.7%	12.7%	3.6%	2.6%

Summary of Physician Outpatient Fee Comparison				
	CT Compared to 5-State Average		CT Compared to Medicare	
	Non-Facility[1]	Facility[2]	Non-Facility[3]	Facility[4]
125-149% Above the Comparison Rate	8.1%	1.8%	1.3%	2.2%
150-174% Above the Comparison Rate	0.4%	0.9%	0.6%	0.0%
175-200% Above the Comparison Rate	0.0%	0.0%	0.2%	0.0%
200% or More Above the Comparison Rate	0.0%	0.0%	1.6%	0.0%
Estimated Current Expenditures	**$213,706,923**	**$20,900,507**	**N/A**	**N/A**
Amount Excluded (No Match)	**$557,547**	**$1,447,441**	**N/A**	**N/A**
Amount Excluded (Outlier)	**$68,936,617**	**$960,150**	**N/A**	**N/A**
Estimated Expenditures at Five-State Benchmark	**$222,667,149**	**$24,109,859**	**N/A**	**N/A**
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	**$8,960,227**	**$3,209,351**	**N/A**	**N/A**
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	**4.2%**	**15.4%**	**N/A**	**N/A**
Estimated Current Expenditures	**N/A**	**N/A**	**$312,038,952**	**$22,753,009**
Amount Excluded (No Match)	**N/A**	**N/A**	**$51,982,037**	**0**
Estimated Expenditures at Medicare Rate	**N/A**	**N/A**	**$423,755,457**	**$36,083,910**
Difference Between Estimated Current Expenditures and Estimated Expenditures at Medicare Rate	**N/A**	**N/A**	**$111,716,505**	**$13,330,901**
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Medicare Rate	**N/A**	**N/A**	**35.8%**	**58.6%**

Key points from these comparisons include the following.

- *Connecticut Medicaid non-facility rates for physician office and outpatient services average 89.2 percent of the Five-State Comparison Rate; rates range from 30.0 to 151.1 percent of the Five-State Comparison Rates. Facility rates for physician office and outpatient services average 71.7 percent of the Five-State Comparison Rate; rates range from 4.6 to 152.7 percent of the Five-State Comparison Rate.*
- *The Connecticut Medicaid non-facility rates for these services average 65.3 percent of the Medicare non-facility rates; rates range from 4.7 to 693.1 percent of the Medicare rates. Facility rates for these services average 60.7 percent of the Medicare rate; rates range from 13.6 to 142.1 percent of the Medicare rate.*
- *70.3 percent of the Connecticut Medicaid non-facility rates for these services are below the Five-State Comparison Rate, with no rates less than 25 percent of the Five-State Comparison Rate.*
- *29.7 percent of the Connecticut Medicaid non-facility rates for these services are above the Five-State Comparison Rate, with no rates more than 175 percent above the Five-State Comparison Rate.*
- *90.5 percent of the Connecticut Medicaid non-facility rates for these services are below the Medicare rate, with 6.3 percent less than 25 percent of the Medicare rate.*
- *7.3 percent of the Connecticut Medicaid non-facility rates for these services are above the Medicare rate, with 1.6 percent of the rates 200 percent or more above the Medicare rate.*
- *For non-facility rates, if Connecticut Medicaid paid services at 100 percent of the Five-State Comparison Rate, there would be an estimated increase of $8,960,227, 4.2 percent of current estimated expenditures, assuming volume and mix of services stay the same. For facility rates, if Connecticut Medicaid paid services at 100 percent of the Five-State Comparison Rate, there would be an estimated increase of $3,209,859, or 15.4 percent of current estimated expenditures, assuming volume and mix of services stay the same.*

Myers and Stauffer reviewed the rate comparisons for specific sets of codes, as defined by CPT: medicine services and procedures, evaluation and management services (office visits), pathology and laboratory services, coronavirus, and alcohol and drug abuse treatment services.

Table 8 shows that for the selected grouping of codes, in comparison to the Five-State Comparison Rates, Connecticut Medicaid average comparison rates range from 30.7 to 226.6 percent of the Comparison Rate, with rates for the HUSKY Primary Care Services at the high end for non-facility services. For facility services, the average comparison rates range from 4.6 to 152.7 percent of the Five-State Comparison Rate, with Evaluation and Management services at the high end.

Table 8: Comparison of Rates by Types of Physician and Outpatient Services to Five-State Comparison

Comparison of Rates by Types of Physician and Outpatient Services to Five-State Comparison				
	Non-Facility		Facility	
CPT/HCPCS Grouping	Comparison Rate Percentage Range	Average Comparison Rate Percentage	Comparison Rate Percentage Range	Average Comparison Rate Percentage
Medicine Services and Procedures	30.7%-151.1%	91.3%	4.6%-141.5%	70.1%
Evaluation and Management	43.3-147.3%	91.1%	39.8%-152.7%	79.9%
Pathology and Laboratory	30.0%-146.6%	77.0%	31.9%-90.7%	74.6%
HUSKY Primary Care	111.6%-222.6%	153.8%	75.1%-134.7%	113.40%

Table 9 shows that, for the selected grouping of codes in comparison to the Medicare comparison rates, Connecticut Medicaid average comparison rates range from 50.2 to 92.5 percent of the Comparison Rate, with rates for the HUSKY Primary Care Services at the high end for non-facility services. For facility services, the average comparison rates range from 56 to 90.3 percent of the Medicare comparison rate. HUSKY Primary Care average comparison rates are the highest, and the other three service code groups are more tightly grouped, ranging from 56 to 68.3 percent of the Medicare comparison rate.

Table 9: Comparison of Rates by Types of Physician and Outpatient Services to Medicare

Comparison of Rates by Types of Physician and Outpatient Services to Medicare				
	Non-Facility		Facility	
CPT/HCPCS Grouping	Medicare Rate Percentage Range	Average Medicare Rate Percentage	Medicare Rate Percentage Range	Average Medicare Rate Percentage
Medicine Services and Procedures	6.8%-693.1%	68.5%	13.6%-142.1%	59.6%
Evaluation and Management	31.9-129.8%	64.7%	34.7%-139.4%	68.3%
Pathology and Laboratory	4.7%-255.7%	50.2%	51%-59%	56.0%
HUSKY Primary Care	74.3%- 47%	92.5%	68.9-101.6%	90.3%

The comparison statistics do not provide separate detail regarding payments to nurse practitioners, physician assistants, and APRNs, who are paid 90 percent of the Medicaid fee schedule. Obstetricians are paid 145 percent of the fee schedule. For comparison purposes, the five state Medicaid agencies use the following policies:

- *Massachusetts pays 85 percent of the fee schedule for certified nurse practitioners, physician assistants, and APRNs.*
- *Maine recently moved APRNs to 100 percent of Medicaid PFS.*
- *New York pays 95 percent of the fee schedule for nurse practitioners.*
- *Oregon does not reduce the fee schedule for physician assistants and nurse practitioners.*
- *Medicare pays nurse practitioners and physician assistants 85 percent and clinical social workers 75 percent of the Medicare PFS.*

HUSKY Health Care Primary Care Fee Schedule

Myers and Stauffer reviewed 81 non-facility and 29 facility codes/rates for HUSKY Health Care Primary Care services provided by the Connecticut Medicaid program and compared the rates to Medicaid programs in the states of Maine, Massachusetts, New Jersey, New York, and Oregon. 50 non-facility and 20 facility codes were compared to Medicare. The information presented in *Table 10* for the codes on the fee schedule. It was not possible to identify specific units for codes on the HUSKY Health Care Primary Care Fee Schedule, so the actual expenditure dollars cannot be added to expenditures for other services.

Table 10: HUSKY Health Care Primary Care Fee Schedule Comparison

HUSKY Health Care Primary Care Fee Schedule Comparison				
	CT Compared to 5-State Average		CT Compared to Medicare	
	Non-Facility	Facility	Non-Facility	Facility
Comparison Rate Percentage Range	111.6%-222.6%	75.1%-134.7%	74.3%-147%	68.9%-101.6%
Average Comparison Rate Percentage	153.8%	113.4%	92.5%	88.7%
Count of Distinct Codes	81	29	55	33
Percentage of CT Codes Below the Comparison Rate	0.0%	20.7%	81.8%	63.6%
76-99% of the Comparison Rate	0.0%	20.7%	76.4%	45.5%
51-75% of the Comparison Rate	0.0%	0.0%	5.45%	18.18%
26-50% of the Comparison Rate	0.0%	0.0%	0.0%	0.0%
0-25% of Comparison Rate	0.0%	0.0%	0.0%	0.0%
Percentage of CT Codes Above the Comparison Rate	100.0%	79.3%	18.2%	36.4%
0-124% Above the Comparison Rate	16.1%	55.2%	16.4%	36.4%
125-149% Above the Comparison Rate	32.1%	24.1%	1.8%	0.0%

HUSKY Health Care Primary Care Fee Schedule Comparison				
	CT Compared to 5-State Average		CT Compared to Medicare	
	Non-Facility	Facility	Non-Facility	Facility
150-175% Above the Comparison Rate	30.9%	0.0%	0.0%	0.0%
176-199% Above the Comparison Rate	17.3%	0.0%	0.0%	0.0%
200% or More Above the Comparison Rate	3.70%	0.0%	0.0%	0.0%

Key points from these comparisons include the following.

- *Connecticut Medicaid non-facility rates for HUSKY Health Primary Care services average 153.8 percent of the Five-State Comparison Rate; rates range from 111.6 to 222.6 percent of the Five-State Comparison Rates. Facility rates for physician office and outpatient services average 113.4 percent of the Five-State Comparison Rate; rates range from 75.1 to 134.7 percent of the Five-State Comparison Rate.*
- *The Connecticut Medicaid non-facility rates for these services average 92.5 percent of the Medicare non-facility rates; rates range from 74.3 to 147 percent of the Medicare rates. Facility rates for these services average 88.7 percent of the Medicare rate; rates range from 68.9 to 101.6 percent of the Medicare rate.*
- *None of the Connecticut Medicaid non-facility rates for these services are lower than the Five-State Comparison Rate. Some rates are 200 percent or more of the Five-State Comparison Rate.*
- *18.2 percent of the Connecticut Medicaid non-facility rates for these services are above the Medicare rate, with no rates less than 75 percent below the Medicare rate.*
- *63.6 percent of the Connecticut Medicaid rates for facility services are below the Medicare rate, with no rates more than 50 percent below the Medicare rate.*
- *36.4 percent of the Connecticut Medicaid facility rates are above the Medicare rate, with no rates more than 125 percent above the Medicare.*

Of note, Medicare and the comparison states have implemented a number of Value-Based Payment (VBP) initiatives through Alternative Payment Methods (APMs) that affect overall payments for physician and outpatient services; these payments are generally paid outside the fee schedule and therefore not included in published fee schedule rates used for rate comparisons.

- *Maine's Primary Care Plus (PCPlus) program is a value-based approach to support primary care. PCPlus offers primary care practices greater flexibility and incentives to meet MaineCare members' health care needs. PCPlus makes population-based payments tied to cost- and quality-related outcomes. These payments are added to the fee-for-service rate.*[20]
- *Massachusetts implemented Primary Care Accountable Care Organizations, which are provider-led entities that are held accountable by MassHealth for the cost of care provided through a calculation of shared savings and shared losses against a benchmark spending target. Under the Demonstration waiver (2016-2021), alternative payment models rewarded quality of care and positive health outcomes.*
- *For the new Demonstration period (2022-2027) MassHealth is making significant investments in primary care, transitioning ACOs away from the fee-for-service model and towards a model that offers more flexibility and supports enhanced care delivery expectations. In the new Demonstration. MassHealth will continue to pay Accountable Care Partnership Plans (i.e., the non-Primary Care ACOs) a set monthly payment per member (a capitation payment) and direct the ACOs to use a portion of that capitation fee to pay their participating primary care practices. Massachusetts provides information about the additional payments in contracts with the ACOs/Primary Care Practices, which does not allow comparison of the additional payments in the fee schedule comparison.* [21]
- *New York has a program called the Preferred Physicians and Children Program (PPAC) which pays enhanced fees for a limited number of primary care services. The comparison of Connecticut rates to the New York rates includes the enhanced payment amounts.* [22]
- *Oregon contracts with Continuing Care Organizations (CCOs) that are required to support patient-centered primary care homes. These VBP payments will increase over the course of the contract between the CCOs and providers.*[23] *Myers and Stauffer did not compare the Connecticut rate to the Oregon rates.*
- *Medicare's Quality Payment Program established two tracks to financially incentivize Medicare providers to deliver high quality, efficient care:*
    - *The Merit-based Incentive Payment System (MIPS) allows eligible providers to earn performance-based payment adjustments.*

[20] https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/inline-files/Primary%20Care%20Plus%20Overview%20Orientation%20%281%29.pdf
[21] www.bluecrossmafoundation.org/sites/g/files/csphws2101/files/2023-6/MH_Demonstration_2023_FINAL_2.pdf
[22] https://regs.health.ny.gov/content/section-5337-preferred-physicians-and-children-program. The enhanced rates used in the comparison are an average of the upstate and downstate NY rates.
[23] https://www.chcs.org/media/PCI-Toolkit-Part-2-Update_081622.pdf

- *The Advanced Alternative Payment Model (Advanced APM) encourages providers to share in the financial rewards and risk of caring for beneficiaries.*[24]

Also not included in the comparisons are payments made through the Connecticut Obstetrical Pay for Performance Program, under which participating providers are eligible for bonus payments if certain quality metrics are met. Bonus payments are based on the total amount of funding available in the bonus pool, spread-out over-all providers. Payments are calculated retrospectively and paid annually.

Physician Anesthesia Services

Myers and Stauffer reviewed 242 codes and rates for physician anesthesia services in the Connecticut Medicaid program and compared the rates to Medicaid programs in the states of Maine, Massachusetts, New Jersey, New York, and Oregon. Myers and Stauffer also compared 253 codes and rates to Medicare's codes and rates.

The comparison of rates for anesthesia is somewhat different than for other services because of the way the fee schedule is structured. Although Medicare includes the Anesthesia Fee Schedule in its PFS, the rates have a different basis than the rates for other physician and practitioner services. Medicare determines payment for anesthesia services by adding base units to time units and multiplying by a conversion factor, using the formula: *(Base units [RVUs] + Time [in units]) x Conversion Factor = Anesthesia Fee Amount*. Connecticut Medicaid and the five comparison states use this same approach. CMS defines Medicare conversion factors; state Medicaid conversion factors are determined by each state. CMS also defines the base units for anesthesia CPT codes and states, including Connecticut, generally use those base units.

For informational purposes, the Connecticut Medicaid conversion factor as published by CMS was compared to the conversion factors from the five states, as shown in *Table 11*:

Table 11: Medicaid Conversion Factor

2023 Conversion Factor	
Connecticut	$14.00
Maine	$14.73
Massachusetts	$19.90
New Jersey	N/A
New York	$10.00
Oregon	$20.78
Medicare	$22.06

[24] https://www.gao.gov/products/gao-24-107106

Anesthesia rates were analyzed by multiplying the Connecticut Medicaid base rate by the conversion factor and compared that to the results of the same comparison calculated using the Five-State Comparison Rate and to Medicare as shown in *Table 12*. Information regarding the minutes billed per claim was not available, and using the average minutes as shown in the claims information would not have provided meaningful information; therefore, adjustments for time, per code was not conducted.

Table 12: Summary of Physician Anesthesia Fee Comparison

Summary of Physician Anesthesia Fee Comparison		
	CT Compared to 5-State Average	CT Compared to Medicare
Comparison Rate Percentage Range	0%-205.7%	0%-95.2%
Average Comparison Rate Percentage	85.6%	62.8%
Count of Distinct Codes	242	275
Percentage of CT Codes Below the Comparison Rate	100.0%	100.0%
75-99% Below the Comparison Rate	100.0%	2.6%
50-74% Below the Comparison Rate	0.0%	94.6%
25-49% Below the Comparison Rate	0.0%	1.1%
0-24% Below the Comparison Rate	0.0%	1.8%
Percentage of CT Codes Above the Comparison Rate	0.0%	0.0%
0-124% Above the Comparison Rate	0.0%	0.0%
125-149% Above the Comparison Rate	0.0%	0.0%
150-174% Above the Comparison Rate	0.0%	0.0%
175-200% Above the Comparison Rate	0.0%	0.0%
200% or More Above the Comparison Rate	0.0%	0.0%
Estimated Current Expenditures	**$12,879,466**	**N/A**
Estimated Expenditures at Five-State Benchmark	**$15,043,676**	**N/A**
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	**$2,164,210**	**N/A**
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	**16.8%**	**N/A**
Estimated Current Expenditures	**N/A**	**$16,832,620**
Estimated Expenditures at Medicare Benchmark	**N/A**	**$26,450,670**
Difference Between Estimated Current Expenditures and Estimated Expenditures at Medicare Benchmark	**N/A**	**$9,618,050**
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Medicare Benchmark	**N/A**	**57.1%**

Key points from these comparisons include the following.

- *Connecticut Medicaid rates are consistently 85.6 percent of the Five-State Average Comparison Rates.*
- *Connecticut Medicaid rates are consistently 62.8 percent of the Medicare rates.*
- *All of the rates Connecticut Medicaid rates are below the Five-State Comparison Rates and the Medicare rates.*
- *If Connecticut Medicaid paid services at 100 percent of the Five-State Comparison Rate, there would be an estimated increase of 16.8 percent of current estimated expenditures, assuming volume and mix of services stays the same.*
- *If Connecticut Medicaid paid services at 100 percent of the Medicare rate, there would be an estimated increase of 57.1 percent of current estimated expenditures, assuming volume and mix of services stays the same.*

Physician-Radiology Services

Myers and Stauffer reviewed 1,597 codes and rates for physician, radiology services in the Connecticut Medicaid program and compared the rates to Medicaid programs in the states of Maine, Massachusetts, New Jersey, New York, and Oregon. Myers and Stauffer compared 1,692 codes to and rates to Medicare's codes and rates, as shown in *Table 13*.

Table 13: Summary of Physician-Radiology Fee Comparison

Summary of Physician-Radiology Fee Comparison		
	CT compared to 5-State Average	**CT compared to Medicare**
Comparison Rate Percentage Range	29.0%-167.2%	8.8%-643.1%
Average Comparison Rate Percentage	93.1%	76.7%
Count of Distinct Codes	1597	1692
Percentage of CT Codes Below Comparison Rate	72.7%	82.3%
75-99% Below the Comparison Rate	58.4%	9.1%
50-74% Below the Comparison Rate	12.7%	53.6%
25-49% Below the Comparison Rate	1.6%	18.9%
0-24% Below the Comparison Rate	0.0%	0.78%
Percentage of CT Codes Above the Comparison Rate	27.3%	17.7%
0-124% Above the Comparison Rate	16.5%	8.1%
125-149% Above the Comparison Rate	7.3%	3.9%
150-175% Above the Comparison Rate	3.5%	1.1%
176-200% Above the Comparison Rate	0.0%	1.0%
200% or More Above the Comparison Rate	0.0%	3.7%
Estimated Current Expenditures	**$40,238,713**	**N/A**

Summary of Physician-Radiology Fee Comparison		
	CT compared to 5-State Average	CT compared to Medicare
Amount Excluded (No Match)	$786,369	N/A
Amount Excluded (Outlier)	$2,873,570	N/A
Estimated Expenditures at Five-State Benchmark	$43,753,104	N/A
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	$3,514,390	N/A
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	8.73%	N/A
Estimated Current Expenditures	N/A	$45,624,412
Amount Excluded (No Match)	N/A	$908,176
Estimated Expenditures at Medicare Rate	N/A	$65,038,839
Difference Between Estimated Current Expenditures and Estimated Expenditures at Medicare Rate	N/A	$19,414,427
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Medicare Rate	N/A	42.6%

Key points from these comparisons include the following.

- *Connecticut Medicaid rates for radiology services average 93.1 percent of the Five-State Comparison Rate; rates range from 29.0 to 167.2 percent of the Five-State Comparison Rates.*
- *The Connecticut Medicaid rates for these services average 76.7 percent of the Medicare rates; rates range from 8.8 to 643.1 percent of the Medicare rates.*
- *72.7 percent of the Connecticut Medicaid rates for these services are below the Five -State Comparison Rate, with 1.6% of the rates below 50 percent of the Five -State Comparison Rate.*
- *27.3 percent of the Connecticut Medicaid rates for these services are above the Five-State Comparison Rate with 0 percent of the rates 175 percent or more than the Five -State Comparison Rate.*
- *82.3 percent of the Connecticut Medicaid rates for these services are below the Medicare rate, with 18.9 percent less than 50 percent of the Medicare rate.*
- *17.7 percent of the Connecticut Medicaid rates for these services are above the Medicare rate, with 3.7 percent of the rates more than 200 percent above the Medicare rate.*
- *If Connecticut Medicaid paid services at 100 percent of the Five-State Comparison Rate, there would be an estimated increase of $3,514,390, or 8.7 percent of current estimated expenditures, assuming volume and mix of services stays the same.*

- *If Connecticut Medicaid paid services at 100 percent of the Medicare rate, there would be an estimated increase of $19,414,427, or 42.6 percent of current estimated expenditures, assuming volume and mix of services stays the same.*

Physician-Surgery Services

Myers and Stauffer reviewed 5,224 non-facility and 1,638 facility codes and rates for physician-surgery services in the Connecticut Medicaid program and compared the rates to Medicaid programs in the states of Maine, Massachusetts, New Jersey, New York, and Oregon (*Table 14*). Myers and Stauffer also compared 5,416 (non-facility) and 1,605 facility codes and rates to Medicare's codes and rates.

Table 14: Summary of Physician-Surgery Fee Comparison

Summary of Physician-Surgery Fee Comparison				
	CT Compared to 5-State Average		CT Compared to Medicare	
	Non-Facility[1]	Facility[2]	Non-Facility[3]	Facility[4]
Comparison Rate Percentage Range	65.9%-109.2%	27.4%-128.1%	4.3%-95.2%	20.6%-193.4%
Average Comparison Rate Percentage	86.8%	77.4%	56.0%	58.3%
Count of Distinct Codes	5171	1638	5706	1717
Percentage of CT Codes Below Comparison Rate	94.1%	94.6%	97.8%	97.3%
75-99% of the Comparison Rate	86.4%	56.4%	3.0%	3.4%
50-74% of the Comparison Rate	7.8%	28.9%	66.6%	73.4%
25-49% of the Comparison Rate	0.0%	9.3%	28.0%	20.3%
0-24% of the Comparison Rate	0.0%	0.0%	0.4%	0.2%
Percentage of CT Codes Above the Comparison Rate	5.9%	5.4%	2.2%	2.7%
0-124% Above the Comparison Rate	5.9%	5.1%	1.1%	1.6%
125-149% Above the Comparison Rate	0.0%	0.3%	0.7%	0.8%
150-174% Above the Comparison Rate	0.0%	0.0%	0.1%	0.2%
175-200% Above the Comparison Rate	0.0%	0.0%	0.1%	0.1%
200% or More Above the Comparison Rate	0.0%	0.0%	0.3%	0.0%
Estimated Current Expenditures	**$41,649,863**	**$15,424,754**	**N/A**	**N/A**
Amount Excluded (No Match)	**$2,549,850**	**0**	**N/A**	**N/A**
Amount Excluded (Outlier)	**$35,475,829**	**$753,570**	**N/A**	**N/A**
Estimated Expenditures at Five-State Benchmark	**$47,616,451**	**$21,782,857**	**N/A**	**N/A**
Difference Between Estimated Current Expenditures and Estimated Expenditures at Five-State Benchmark	**$5,966,588**	**$6,358,103**	**N/A**	**N/A**

Summary of Physician-Surgery Fee Comparison				
	CT Compared to 5-State Average		CT Compared to Medicare	
	Non-Facility[1]	Facility[2]	Non-Facility[3]	Facility[4]
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Five-State Benchmark	14.3%	41.2%	N/A	N/A
Estimated Current Expenditures	N/A	N/A	$77,843,338	$16,216,784
Amount Excluded (No Match)	N/A	N/A	$3,173,180	0
Estimated Expenditures at Medicare Rate	N/A	N/A	$119,824,123	$26,219,966
Difference Between Estimated Current Expenditures and Estimated Expenditures at Medicare Rate	N/A	N/A	$41,980,785	$10,003,182
Percent Change Between Current Estimated Expenditures and Estimated Expenditures at Medicare Rate	N/A	N/A	53.9%	61.7%

Key points from these comparisons include the following.

- *Connecticut Medicaid non-facility rates for Physician Surgery services average 86.8 percent of the Five-State Comparison Rate; rates range from 65.9 to 109.2 percent of the Five-State Comparison Rates. Facility rates average 77.4 percent of the Five-State Comparison Rate; rates range from 27.4 to 128.1 percent of the Five-State Comparison Rate.*
- *The Connecticut Medicaid non-facility rates for these services average 56 percent of the Medicare non-facility rates; rates range from 4.3 to 95.2 percent of the Medicare rates. Facility rates for these services average 58.3 percent; rates range from 20.6 to 193.4 percent.*
- *94.1 percent of the Connecticut Medicaid non-facility rates for these services are below the Five-State Comparison Rate, with no rates less than 25 percent of the Five-State Comparison Rate. 94.6 percent of the Connecticut Medicaid rates for facility services are below the Five-State Comparison Rate, with no rates less than 25 percent of the Five-State Comparison Rate.*
- *5.9 percent of the Connecticut Medicaid non-facility rates for these services are above the Five-State Comparison Rate, with no rates more than 125 percent above the Five-State Comparison Rate. 5.4 percent of the Connecticut Medicaid rates for the facility services are above the Five-State Comparison Rate, with no rates more than 150 percent above the Five-State Comparison Rate.*

- *97.8 percent of the Connecticut Medicaid non-facility rates for these services are below the Medicare rate, with 28.0 percent of rates more than 50 percent below the Medicare rate. 97.3 percent of the Connecticut Medicaid rates for the facility services are below the Medicare rate, with 20.3 percent of rates below 50 percent of the Medicare rate.*
- *2.7 percent of the Connecticut Medicaid rates for the facility services are above the Medicare rate.*
- *If Connecticut Medicaid paid non-facility services at 100 percent of the Five-State Comparison Rate, there would be an estimated increase of $5,966,588, or 14.3 percent of current estimated expenditures, assuming volume and mix of services stays the same.*
- *If Connecticut Medicaid paid facility services at 100 percent of the Five-State Comparison Rate, there would be an estimated increase of $6,358,103, or 41.2 percent of current estimated expenditures, assuming volume and mix of services stays the same.*
- *If Connecticut Medicaid paid facility services at 100 percent of the Medicare rate, there would be an estimated increase of $10,003,182 or 61.7 percent of current estimated expenditures, assuming volume and mix of services stays the same.*
- *If Connecticut Medicaid paid non-facility services at 100 percent of the Medicare rate, there would be an estimated increase of $41,980,785 or 53.9 percent of current estimated expenditures, assuming volume and mix of services stays the same.*

Summary of Comparison Metrics

The following tables provide a summary of the metrics provided related to each of the fee schedules reviewed. *Table 15* provides information about the comparison of Connecticut Medicaid fee schedule rates to the five selected Medicaid programs.

Table 15: Code Analysis Medicare

Fee Schedule	Code Analysis Summary Medicare					
	Number of Distinct Codes Analyzed	Total Expenditure Analyzed ($ in Millions)	Number of Distinct Codes Removed (No-Match)	Number of Distinct Codes Removed (Outlier)	Total Expenditures Not Analyzed ($ in Millions)	Percent of Expenditures Analyzed
Physician and Outpatient						
• Non-facility	1,649	312.0	302	0	51.9	85.7%
• Facility	228	22.7	302	0	0.0	100.0%
Physician Anesthesia	275	16.8	0	0	0.0	100.0%

Fee Schedule	Code Analysis Summary Medicare					
	Number of Distinct Codes Analyzed	Total Expenditure Analyzed ($ in Millions)	Number of Distinct Codes Removed (No-Match)	Number of Distinct Codes Removed (Outlier)	Total Expenditures Not Analyzed ($ in Millions)	Percent of Expenditures Analyzed
Physician Radiology	1,692	45.6	171	0	0.9	98.1%
Physician Surgery						
• Non-facility	5,706	77.8	196	0	3.2	96.0%
• Facility	1,717	16.2	198	0	0.0	100.0%
Total		**491.1**			**56.0**	**89.8%**

Table 16 provides a summary of the comparison of Connecticut fee schedules to the Medicare fee schedule for those services where there are Medicare fees.

Table 16: Summary of Medicare Comparison

Fee Schedule	Medicare Comparison[25]					
	Comparison Rate Range[26]	Average Comparison Rate[27]	Total Current Expenditures ($ in Millions)[28]	Total Expenditures at Medicare Benchmark ($ in Millions)[29]	Estimated Increase (Decrease)	Increase (Decrease) To Pay at Medicare Benchmark
Physician/ OP						
• Non-facility[30]	4.7%-693.1%	65.3%	312.0	423.7	111.6	35.8%
• Facility	13.6%-142.1	60.7%	22.7	36.1	13.3	58.9%
Anesthesia	0.0%-95.2%	62.8%	16.8	26.5	9.6	57.1%
Physician Radiology	8.8%-643.1%	76.6%	45.6	65.0	19.4	42.5%

[25] Medicare rates were not available for comparison for autism spectrum disorder services, behavioral health services not on the Physician and Outpatient Fee Schedule, and Dental services.
[26] The Comparison Rate Range is the range of the comparison rates for each code.
[27] Connecticut Medicaid reimbursement as a percentage of the 5-State Medicaid average comparison rate for all selected procedure codes.
[28] Current Connecticut Medicaid rate times the units paid in SFY 2023.
[29] SFY 2023 units multiplied by the Medicare rate.
[30] 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.

Fee Schedule	Medicare Comparison[25]					
	Comparison Rate Range[26]	Average Comparison Rate[27]	Total Current Expenditures ($ in Millions)[28]	Total Expenditures at Medicare Benchmark ($ in Millions)[29]	Estimated Increase (Decrease)	Increase (Decrease) To Pay at Medicare Benchmark
Physician Surgery						
• Non-facility	4.3%-495.2	56.0%	77.8	119.8	41.9	53.9%
• Facility	20.6%-193.4%	58.3%	16.2	26.2	10.0	61.7%
Total			**491.1**	**697.3**	**205.8**	**41.9%**

Table 17 identifies the number of distinct codes Myers and Stauffer reviewed and compared to the Medicaid fee schedules of the five comparison states for each of the Phase 1 services.[31] Myers and Stauffer also identified the number of codes which are an outlier to the rates in the five comparison states, and codes that could not be matched with insufficient comparison points (i.e., two or fewer comparison rates).

Table 17: Code Analysis Five-State Comparison

Fee Schedule	Code Analysis Summary Five-State Comparison					
	Number of Distinct Codes Analyzed	Total Expenditure Analyzed ($ in Millions)	Number of Distinct Codes Removed (No-Match)	Number of Distinct Codes Removed (Outlier)	Total Expenditure Not Analyzed ($ in Millions)	Percent of Expenditures Analyzed
ASD	9	50.8	2	0	0.4	99.2%
Behavioral Health Services	12	39.1	4	0	3.3	92.2%
Dental Adult	179	128.6	46	0	0.9	99.3%
Dental Pediatric	191	211.6	46	0	0.9	99.6%
Physician and Outpatient						
• Non-facility	1635	218.2	147	165	69.4	75.9%
• Facility	221	20.9	27	4	2.3	90.1%
Physician Anesthesia	242	12.8	0	22	0.1	99.2%
Physician Radiology	1597	40.2	81	212	3.5	92.0%

[31] Distinct codes include codes with unique codes as well as codes that have a modifier.

Fee Schedule	Code Analysis Summary Five-State Comparison					
	Number of Distinct Codes Analyzed	Total Expenditure Analyzed ($ in Millions)	Number of Distinct Codes Removed (No-Match)	Number of Distinct Codes Removed (Outlier)	Total Expenditure Not Analyzed ($ in Millions)	Percent of Expenditures Analyzed
Physician Surgery						
• Non-facility	5171	41.6	134	589	37.9	52.3%
• Facility	1638	15.4	217	79	0.7	95.7%
Total		**779.2**			**119.4**	**84.7%**

The results of the comparison of Connecticut Medicaid fee schedules to the fee schedules of the five state Medicaid programs are shown in *Table 18*.

Table 18: Summary of Five-State Comparison Analysis

Fee Schedule	Five-State Comparison					
	Comparison Rate Range[32]	Average Comparison Rate[33]	Total Current Expenditure ($ in Millions)[34]	Total Expenditures at 5-State Comparison Benchmark ($ in Millions)[35]	Estimated Increase ($) (Decrease)	Increase (Decrease) To Pay At 5-State Comparison Benchmark
ASD	61.7-644.2%	196.8%	50.8	64.7	13.8	27.3%
Behavioral Health Services	13.3%-163.6%	62.3%	39.1	81.5	42.4	108.5%
Dental Adult	2.4%-1312.5%	117.7%	128.6	151.9	23.3	18.2%
Dental Pediatric	6.3% - 710.1%	109.9%	211.6	192.3	(19.2)	(9.1)%
Physician and Outpatient						
• Non-facility[36]	30-151.1%	89.2%	218.2	227.7	9.4	4.3%
• Facility	4.6-152.7%	71.7%	20.9	24.1	3.2	15.3%

[32] The Comparison Rate Range is the range of the comparison rates for each code.

[33] Connecticut Medicaid reimbursement as a percentage of the Five-State Medicaid average comparison rate for all selected procedure codes.

[34] Current Connecticut Medicaid rate times the units paid in state fiscal year (SFY) 2023.

[35] SFY 2023 units multiplied the other states' average rate.

[36] 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.

Fee Schedule	Five-State Comparison					
	Comparison Rate Range[32]	Average Comparison Rate[33]	Total Current Expenditure ($ in Millions)[34]	Total Expenditures at 5-State Comparison Benchmark ($ in Millions)[35]	Estimated Increase ($) (Decrease)	Increase (Decrease) To Pay At 5-State Comparison Benchmark
Physician Anesthesia	85.6%-85.6%	85.6%	12.8	15.0	2.1	16.8%
Physician Radiology	29%-167.2%	93.1%	40.2	43.7	3.5	8.7%
Physician Surgery						
• Non-facility	27.4%-	86.8%	41.6	47.6	5.9	14.3%
• Facility	128.1%	77.4%	15.4	21.7	6.3	41.2%
Total			**779.2**	**870**	**92**	**11.7%**

The review of codes on the Physician and Outpatient Fee Schedule, together with codes on the HUSKY Primary Care, Anesthesia, Radiology, and Surgery Fee Schedules, shows that in the comparison of Connecticut Medicaid rates to the Five-State Comparison Rate for these services, there is variation in comparison percentages across the various fee schedules. The review of codes on the Physician and Outpatient Fee Schedule, together with codes on the Anesthesia, Radiology, and Surgery Fee Schedules, shows that individual Connecticut Medicaid rates on these fee schedules are both above and below the Comparison Rate but when averaged are less than the Five-State Comparison Rate.

For dental services, the comparison of fees to the Five-State Comparison Rate indicates that fees for adult services are, on average, are lower than pediatric services, and comparison rates vary considerably from service to service. On average, both the Adult and Pediatric dental rates are higher than the Five-State Comparison Rate but there are codes well below and above the Five-State Comparison Rate for both adult and pediatric dental services.

The code comparisons for BHS and ASD were somewhat limited because of issues related to the definition of services and use of different codes across the five Medicaid programs. These comparison issues point to areas where codes should be reviewed as discussed in the Recommendations, and fee schedules could be modified to better represent the services delivered. On average, the ASD codes for treatment are significantly below the Five-State Comparison Rate, while the rates for diagnostic services were significantly higher. Similarly in BHS, the majority of the codes were below the comparison rate.

Finally, comparison to Medicare rates indicates that rates are almost consistently below the benchmark, with the exception of some rates on the HUSKY Primary Care Fee Schedule being higher.

Observations Regarding Fee Schedule Methodologies and Rates

In addition to the development of comparison metrics for the various fee schedules, Myers and Stauffer met with Department staff and reviewed current Connecticut Medicaid fee schedule policies, reviewed relevant Medicare regulations regarding payment methodologies, and the methodologies of the five comparison states.[37] A summary of the reviews and data sources are found in *Appendix A*. This review of methodologies provided additional information to support the rate study, as follows.

- *Some Phase 1 services fee schedules are based on well-established and documented methodologies; the methodologies and calculations for other fee schedules are based on historical methodologies that have not been updated since implementation.*
    - *The Physician and Outpatient Fee Schedule and the HUSKY Health Primary Care Fee Schedules were both-based on the Medicare PFS, which in turn is based on the RBRVS.[38] The RBRVS-based methodology is based on the principle that payments for various services should reflect their relative resource use. Researchers, policymakers, medical societies, and others support the review and annual updating of the methodology, which is used widely by state Medicaid programs and other payers. Connecticut Medicaid developed its PFS effective 2007, and rates were established as 57.5 percent of the Medicare rates in effect at that time.*
    - *Physician Radiology and Surgery Fee Schedules are also based on the RBRVS components of the Medicare PFS. Included in the Medicare PFS, but based on a different method for rate calculation, are the Medicare anesthesia rates. Connecticut also uses these Medicare rates as the basis of its Anesthesia Fee Schedule. Rates for these services were established as 57.5 percent of the Medicare rates in effect at that time.*
    - *For all of the physician and outpatient services, including anesthesia, radiology, and surgery, the rates are based on a percentage of Medicare, making it relatively easy to calculate rates and consistent with the methodologies of the comparison states and other Medicaid programs across the country.*
    - *The Dental Fee Schedule (Adult and Pediatric) was established in 2004 using approximately 60 percent of the 50th percentile of dentists' charges in Connecticut. The dental charge data was derived from a commercial data base and rates were meant to approximate rates paid by Connecticut Medicaid managed care organizations that, at the time, were administering the dental benefit. The Department now uses a database of Connecticut*

[37] Appendix A provides data sources and a summary of the review of Connecticut's and other states' methodologies.
[38] This fee schedule was implemented by CMS in 1992.

dentists' charges to develop rates for new codes as they are introduced, but it is not clear how the 2004 source was derived or how it compares to the database of charges now in use to price new codes.

- *The fee schedule methodologies for behavioral health services and ASD services are based on historical data. The methodology for those codes on the Behavioral Health Clinician fee schedule are known, but for the remainder of codes, the methodology is based on historical data that has not been updated. DSS updated the ASD fee schedule in 2021 but did not review the rate methodology. Other BHS codes are spread between multiple fee schedules based on rate type, there was not sufficient documentation to determine if they were updated using a single rate methodology or as part of a rate type.*

- *None of the methodologies for the Phase 1 services include a provision for regular review or updating of rates. There have been some ad hoc updates to the fee schedules to address access issues (Dental Fee Schedule) and based on legislation (Physician Outpatient, HUSKY Primary Care, Anesthesiology, Radiology, Surgery Fee Schedules).*
- *Connecticut Medicaid's approaches to service definition and use of coding systems for some services is not generally consistent with the comparison state Medicaid programs.*
  - *Within the dental services area, DSS uses both CPT and CDT codes. This is in contrast to the methodologies of the selected states that rely primarily on CDT codes (except for oral surgery, some radiology, and office visits).[39] Further, the review of the Dental Fee Schedule in comparison to the fee schedules of other states indicates that other states are using dental codes that Connecticut Medicaid does not (more than 500 codes), and that Connecticut is using codes that other states do not.*
  - *For behavioral health services that are not included in the Physician and Outpatient fee schedule, Connecticut and each of the five states do not always use the same codes to report services and have developed fee schedule rates that are specific to those codes as they are defined. These differences are not unexpected, as the systems of care are evolving, and Medicaid programs begin to cover services not historically funded through Medicaid; many states*

[39] The CDT code set is maintained by the American Dental Association and consists of procedural codes for oral health and adjunctive services provided in dentistry. According to the ADA, where insurance is involved, the standard practice is to submit a claim first to the dental insurance plan and if denied and covered under a medical benefit, to then bill the health insurance plan with CPT. CPT is maintained by the American Medical Association and used to report medical procedures. The five state Medicaid programs use CDT for their dental fee schedules, and CPT for oral surgery. Source: https://www.ada.org/resources/practice/dental-insurance/frequently-asked-questions-regarding-dental-codes.

have adopted health homes and other types of system models that rely upon bundled rates that are not as easily comparable.

- *The majority of the services included in the Psychologist Fee Schedule are reported with CPT codes. For other services which rely on HCPCS and not CPT codes, Connecticut Medicaid in many cases defines services differently and uses different codes than do other states.[40] This is not unusual, as states design their fee schedules for BHS in consideration of the provider community and how services are delivered in the state; many states have adopted health homes and other types of system models that rely upon bundled rates that are not easily compared to other states. HCPCS codes provide a structure for billing that mirrors CPT codes but provides states with the flexibility to write service descriptions that reflect the delivery of services for that code and to establish reimbursement rates based on those services descriptions. However, this flexibility in HCPCS codes makes it difficult to compare rates across states and any matches (even when matching to the same code) require careful examination to determine that they are approximate comparison points.*
- *The ASD and BHS Fee Schedules include codes for services that are not used in the comparison states. While it is not unusual for states to adopt codes based on the way services are delivered; since Connecticut Medicaid has not reviewed or updated rates in years, there is no explanation as to why some codes are used in place of others. For ASD services, Connecticut Medicaid uses the same codes that are in other fee schedules and applies different fees, instead of using procedure code modifiers to apply to a code that has a single rate across all fee schedules.*
- *There are different codes for the same or very similar services used in different fee schedules. For example, adaptive behavior treatment is currently billed using 97153 on the ASD Fee Schedule and 0373T on another Behavioral Health Fee Schedules. Each code has a different rate although the underlying provider qualifications and the services provided may be nearly identical. Having different rates for substantively the same service may create incentives for providers to serve one population in favor of another. Services that are dependent upon the individual's diagnosis may skew the rate of diagnosis as families seek to gain needed services.*

[40] The HCPCS is produced by CMS. HCPCS is a collection of standardized codes that represent medical procedures, supplies, products and services. The CPT is a subset of HCPCS, developed by the American Medical Association, and used to report medical procedures and services.

Recommendations Regarding Updating Fee Schedules

Based on the review of the methodologies and the metrics as described above, Myers and Stauffer make the following recommendations.

Autism Spectrum Disorder

- ***Increase direct service treatment rates up to the Five-State Comparison Rate as the first phase of rate adjustments for ASD services.*** *Determine also whether policy changes are needed to address utilization of some ASD services.*
- ***Within the next two to three years, adjust rates using an independent rate model****, where rates are built from the ground up and based on the sum of independently determined cost components and market factors. The rate model will create transparency and support ongoing management and updating of rates.*
- ***The rate model development should include an ABA provider survey that captures direct care wages and benefits costs, program costs, employee expenses, administrative costs, and other cost components that should be determined in conjunction with a provider advisory group****. Survey data can be supplemented with market data, such as wage information from the Bureau of Labor Statistics, and publicly available inflation indices. The new methodology should be documented for re-use and transparency.*
- ***Determine whether rates should be established based on education level of providers.*** *Some states, for example, assign different rates depending on whether the provider has attained a master's degree or above. This is common in autism therapy, where the national licensing board recognizes different licensure at the bachelor's, master's, and doctoral levels. Currently, Connecticut Medicaid is paying for services to support behavior program development, documentation, and training of direct service staff. This policy is not consistent with the policies in other states that, instead, structure rates around education level of provider to recognize the different roles each takes in service delivery.*
- *As part of the rate model development,* ***review and update procedure codes that are used in common in the ASD fee schedule and other fee schedules to eliminate duplicate service types and create a standardized code set for behavioral therapy*** *(regardless of diagnosis) that can be used by any qualified provider.*
- ***Eliminate duplicate codes for services that are provided by different providers with different rates****. As DSS collects information through a provider survey and adjust rates, it should review current codes and their use.*
- ***After the initial rate adjustments, review rates every five years with new cost data and market information. Review rates midway through the rate period, applying an***

inflation factor as possible to maintain consistency of fee schedules with base information.

Behavioral Health Services (Behavioral Health Clinician, Clinic-Medical, Clinic-Rehabilitation, Psychologist).

- ***Increase rates up to the Five-State Comparison Rate as a first step in rate updating.***
- ***Within the next two to three years, adjust rates using an independent rate model****, where rates are built from the ground up and based on the sum of independently determined cost components and market factors. The rate model will create transparency and support ongoing management and updating of rates.*
- ***At the time of rebasing, examine and revise behavioral health services definitions so that they are reflective of each service as it is provided currently****. Service definitions, as well as provider qualifications, may change as new evidence-based models are created, which may include the creation of new specialists or provider types (e.g., Alcohol and Drug Counselors as a subset of Licensed Counselor or Marriage and Family Counselor).*
- ***Use a provider survey to obtain cost information to develop the independent rate model.*** *The new rate methodology should include an examination of current codes and service definitions and modify those as necessary to better reflect how services are delivered in Connecticut. Survey data can be supplemented with market data, such as wage information from the Bureau of Labor Statistics, and publicly available inflation indices. The new methodology should be documented for re-use and transparency.*
- ***Adjust rates every five years with new 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.***

Dental Services Fee Schedules (Adult and Pediatric) and Rate

- ***Phase in a single fee schedule for adult and pediatric services.*** *Of the comparison states, only Massachusetts and New Jersey have a separate fee schedule for adult dental services and pediatric dental services. The analysis of rates indicates that the rates for adult dental services compare less favorably to the benchmarks than do the rates for pediatric dental services.*
- ***Adjust dental fees using a standard benchmark****, which could be a specified percentage of the Five-State Benchmark,. If DSS determines that some codes should be paid at a different percentage of the fee schedule, (e.g., by specialty or by type of service to preserve access to those services) document the policy, rationale, and decisions related to a change, and maintain rates at the same percentage of the benchmark. For example, if the fee schedule rates for endodontic services is 125 percent of the adult dental rates, the*

endodontic rates should always be 125 percent of the adult dental rates, whether rates are increased or decreased, new codes are added, etc. Within the dental fee schedules, there is a large variation in comparison values across various services, resulting from ad hoc changes to the fee schedule to address access issues. DSS should review these rates in comparison to the selected benchmark, determine if variations are warranted, and create appropriate incentives for service delivery and correct coding. Document the methodology for reuse and transparency.

- ***Review the fees for oral surgery in the Physician-Surgery Fee Schedule and determine if the fees as a percent of benchmark are consistent with fees in the Dental Fee Schedule.***
- ***Determine which codes/services should be paid at a different percentage of the fee schedule (e.g., endodontics), document the rationale and decisions for change, and maintain those levels each year**. DSS has increased rates for certain services to improve access to those services.*
- *DSS should also evaluate policy related to the payment of dental hygienists at public health departments and determine if rates to these providers should continue at 90 percent of the dental fee schedule rates. Some states do not reduce the dental rates for these providers; others use varying percentages. DSS should consider how increasing the percent of the fee schedule could address any access issues that may exist.*
- ***Complete the review of codes used in the dental fee schedule**. DSS has been working to delete old codes and add new codes to reflect changes in the way dental services are being delivered. Myers and Stauffer also found a number of codes that are reported using CPT codes instead of CDT codes. Although there are a relatively small number of units reported for these codes, DSS should delete these codes and replace them with CDT codes as applicable.*
- ***For new codes, apply the same percentage of the current benchmark to calculate a rate.** After fee schedules are adjusted, DSS should maintain the relationship of those fee schedules to benchmark rates as appropriate (i.e., given the level of expenditures for the service, DSS can estimate what percentage of benchmark it should maintain across all services). This approach will promote equity across provider categories based on DSS policies and priorities.*
- ***Adjust rates at least every five years.** The rebasing would be based on new benchmark data.*

Physician and Outpatient, HUSKY Health Primary Care, Anesthesia, Radiology, and Surgery Fee Schedules

- ***For services with a methodology based on a percent of Medicare, adjust using the Medicare fee schedule**. These Phase 1 services are: Physician-Outpatient (non-facility and*

facility), Physician-Anesthesiology, Physician-Radiology, Physician-Surgery (non-facility and facility).

- ***Adjust the fee schedule rates using a consistent percentage of the current Medicare Physician Fee Schedule (PFS).*** *Where DSS determines that the percentage of Medicare should be different, either based on physician or practitioner specialty or type of service, document the rationale and decision making and make further updates that reflect these decisions. For example, DSS may want to continue to pay the HUSKY Health Care Rates at higher rates than those listed in the Physician and Outpatient Fee Schedule. Currently, the percentage of the Connecticut Physician and Outpatient Fee Schedule and rates in comparison to Medicare varies significantly due to ad hoc changes in the fee schedule and pricing of new codes. These differences are, in many cases, not related to specific policy goals, and rebasing will allow DSS to make policy decisions regarding if and by how much rates should be adjusted from a standard percent of Medicare rates.*
- ***Determine if policies related to paying Advance Practice Registered Nurses and Physician Assistants should be changed to promote access to services****. Several of the comparison states do not reduce the physician payment rates for these providers; others use varying percentages. DSS should consider how increasing the percent of the fee schedule could address any access issues that may exist.*
- ***Update fee schedules each year, consistent with the updates that the Centers for Medicare & Medicaid Services (CMS) makes to the Medicare PFS.*** *These updates include implementation of new codes, deletion of old codes, and changes in payment policies. If additional funding is available, adjust rates to a common percentage of Medicare as described above. Implement changes even if no additional funding is available (i.e., the changes will be budget neutral). These changes are needed to reflect changes in care delivery and resource costs that CMS identifies through its review of the fee schedule. For example, technology changes can change the resources (and relative values) to deliver care, and the result may be a redistribution of certain relative values and rates.*

Appendix

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, an analysis was conducted for the following tasks.

1. Codes from each fee schedule were grouped into logical breakdowns for comparison purposes, as follows in *Table 19:*

Table 19: Fee Schedule Code Groupings

Fee Schedule Code Groupings		
Physician and Outpatient	CPT grouping	• Medicine Services and Procedures • Evaluation and Management • Pathology and Laboratory • Coronavirus • Procedures and Professional Services • HUSKY Health Primary Care
	Facility vs. Non-facility	• Maintained groupings for rate comparisons, for CT and other states, and Medicare, where possible
Dental Services	CDT grouping	• Diagnostic and Preventive • Oral and Maxillofacial Surgery • Other Services
Anesthesia and Nurse Anesthetist Services	CPT grouping	• Head, Neck, & Chest • Upper Body • Lower Body • Other
Behavioral Health Services	Codes that are included in multiple fee schedules	• Review of CPT codes is included in the physician codes analysis. • Review of HCPCS codes makes up the Behavioral Health analysis. • ASD codes are addressed separately.

2. Paid claims for each code were identified with the number of units of services for each code. DSS generated a report of claims incurred and paid during SFY 2023 (July 2022 to June 2023) for the select providers and fee schedules. Claims listed were fully adjudicated, i.e., adjustment claims were removed. Removed from the analysis were units for crossover claims, where Connecticut Medicaid paid only the covered amounts that Medicare did not pay, and any claims that indicated zero payment.

3. For codes where it was not possible to make a comparison, were identified and removed from the analysis. Failure to remove these codes would have distorted the calculations and estimated budget impacts. Also removed were units that were paid at 90 percent of the fee schedule rates (nurse practitioners, physician assistants, and APRNs). In total, about 1.98 million units and associated payments of $98,763.242 were removed. Whenever there was only one rate type for a unique code and modifier combination, Myers and Stauffer used codes and modifiers to match paid claims units with the fee schedule rate. If a code and modifier combination was associated with more than one rate type, the code, modifier, and average allowed amount was used to match paid claims units with the fee schedule rate. Because the claims data does not include rate type information, wherever a code and modifier combination were associated with multiple rate types, it was not possible to assign claims to a specific rate type. Therefore, Myers and Stauffer allocated the total number of units for the code and modifier combination evenly among all rate types. For example, if a code and modifier combination had two rate types and 20 total units, 10 units were allocated to each rate type. Further investigation would be necessary to precisely identify total paid units for these codes, modifiers, and rate type combinations.
4. Rates of selected states and Medicare were identified from the most recent publicly available information regarding published fee schedules. Medicare rates are from the 2023 Medicare PFS. Other state Medicaid rates are from published fee schedules obtained in March 2023, and the Connecticut Medicaid rates are rates in effect on October 1, 2023.
5. For some codes, the particular features of Connecticut's or other states' fee schedules precluded one-to-one comparison of rates. In those cases, the following adjustments were made as outlined in *Table 20*.

Table 20: Fee Schedule Modifications

Fee Schedule Feature	Analysis Modifications to Address Fee Schedule Features
Same codes appear on multiple fee schedules.	• Grouped common codes into a single fee schedule for analysis. • Oral surgery codes on the dental fee schedule, which are identified with CPT codes and corresponding units of service, were analyzed with the Physician and Outpatient Fee Schedule codes. • Physician-Radiology Fee Schedule codes on the Dental Fee Schedule were analyzed with the Physician-Radiology Fee Schedule Codes. The units of service are also grouped with the Physician and Outpatient Fee Schedule codes. • Coronavirus codes on the Dental Fee Schedule were analyzed with the Physician and Outpatient Fee Schedule codes. The units of service are also grouped with the Physician and Outpatient Fee Schedule codes. • The codes associated with the HUSKY Health Primary Care Fee Schedule were analyzed with the Physician and Outpatient codes. • Behavioral Health Clinician CPT Codes were analyzed with the Physician and Outpatient Fee Schedule codes. HCPCS codes for behavioral health services were analyzed together.

Fee Schedule Feature	Analysis Modifications to Address Fee Schedule Features
	• Codes used on multiple fee schedules for ASD services were grouped together separately for comparison.
Services are defined differently by comparison states.	For non-physician and other professional services that are not reported with CPT codes, states use HCPCS to report services. States vary in how they use HCPCS, however, this makes it difficult to compare services. • For codes where an exact 1:1 code match did not exist, this study used provider requirements, state plans, policy materials, and service description information to identify codes that matched similar factors for the Connecticut Medicaid codes. • In addition, adjusted units of service were used to match service units for Connecticut Medicaid. For example, if one unit for a Connecticut Medicaid procedure code represented 15 minutes of service time, and a similar service from a comparison state represented an hour, the rate for the comparison state would be divided by four to arrive at the rate per 15 minutes. As another example, the CT code for crisis Intervention is S9484 (crisis intervention, mental health services, per hour), but other states may use H2011 (crisis intervention service, per 15 minutes). A crosswalk was conducted for code comparison purposes, but where cross-walking was not possible (for example, H0032 is to report a separate encounter for coordinating / discussing / completing a treatment plan with the client) it was not possible to compare the Connecticut Medicaid codes to the Five-State Comparison State codes. Connecticut was the only state found to use this code for the development of behavior treatment plans.
State has different peer group for services/does not recognize facility vs. non-facility rates were applicable.	• Under the Medicare PFS, which is the basis for the Physician and Outpatient Fee Schedule for Connecticut Medicaid and the five comparison states, some procedures have separate rates for physicians' services when provided in facility and non-facility settings.[41] All states except New Jersey list a facility rate and non-facility rate for select codes on their fee schedules. To address the different approach for New Jersey rates, the study included the applicable New Jersey Medicaid rates in both the non-facility and facility state averages. • New Jersey has separate rates for specialists and non-specialists for fee schedule services. Each of these rates was included in the Five-State Comparison Rate. Only Massachusetts and New Jersey have separate rates for adult and pediatric dental care. The study compared the Connecticut Medicaid rates to each of the rates of the other states.
Some codes appear on the fee schedules under review but were not part of Phase 1 services.	• Some fee schedules, such as the Clinic Rehabilitation and Clinic Medical Fee Schedules, include some codes that were part of the Behavioral Health Clinician Fee Schedule (e.g., H0031), but other codes that will be included in the Phase 2 comparison.

[41] Medicare physician and outpatient services that are paid under the PFS may have differing payment amounts based on where a service was provided. In general, facility services are provided within a hospital, ambulatory surgery center, or skilled nursing facility. Non-facility services are provided everywhere else and include outpatient clinics, urgent care centers, home services, etc. Non-facility services generally have a higher reimbursement rate due to a higher RVU for the non-facility practice expense amount. In a facility setting, such as a hospital, the costs of supplies and personnel that assist with services - such as surgical procedures - are borne by the hospital, whereas those same costs are borne by the provider of services in a non-facility setting. Source: https://www.ama-assn.org/about/rvs-update-committee-ruc/rbrvs-overview.

6. The determined average of five-state rates and is referred to as the Five-State Comparison Rate. The Medicare rate is a single point.
7. For dental services, the Five-State Comparison Rate was used as a comparison point.
8. Removed were any rate comparisons from the Five-State Comparison where there were not at least two comparisons.
9. Connecticut Medicaid codes and rates were compared to two benchmarks: the Five-State Comparison Rate and the Medicare rate. For dental codes and rates, Connecticut Medicaid was compared to the Five-State Comparison Rate. Connecticut Medicaid rate(s) were calculated as a percent of the comparison rate(s).
10. Outliers were comparisons where the Connecticut Medicaid rate as a percent of the comparison rate was extraordinarily high or low. Outliers occurred for a number of reasons, such as the other state rates appeared invalid (e.g., $.01 per unit) and those outliers were removed from the analysis in the Five-State Comparison Rate analyses.
11. A series of metrics were generated to describe the comparisons.