Medicaid Rate Evaluation Process

Medicaid Rate Study Recommendation

The comprehensive Medicaid Rate Study was conducted by Myers and Stauffer in two phases between 2023 and 2025. Phase One was released in February 2024 and Phase 2 in January 2025. The rate study benchmarked Connecticut Medicaid rates to Medicare and peer states were applicable.

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

The rate study made multiple recommendations, but this presentation will focus on the rate study recommendation to:

Establish a formal rationale and comprehensive rate setting process that periodically reviews rates.

The rate study found that the current system does not include timelines for fee schedule rate adjustments, nor does it recognize increases or changes in the system, such as inflation, workforce changes, and updates to clinical best practices. This makes it difficult for providers and the Department to track rates on an ongoing basis.

- **Currently, rate changes are 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 increases without any evidence-based assessment of sufficiency of rates by service across the entire program.

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

Medicaid Rate Study Recommendation

The rate study recommended the development of a *rational rate setting process* based on successful strategies implemented in other state Medicaid programs. A rate evaluation process supports the Department's goal to:

- Develop appropriate rates and payment methods.
- Develop methodological assessments for member access across the program.
- Develop and refine value-based payment models that improve member outcomes and contain costs.
- Invest resources in enhancing coordination of care and prioritizing services that prevent or reduce disease burden instead of acute disease treatment.

The **Medicaid Rate Evaluation Process:**

1. Establishes a set schedule for regular rate review and adjustment of Medicaid rates paid to *all* Medicaid providers.
2. Formalizes a clear and transparent process for rate determination via public notice, presentation, and public comments on proposed rates or program changes.
3. Ensures review of relevant state and national data to inform rate amounts and payment models, with emphasis on models that promote high value services, member access and explore value-based reimbursement when appropriate.

Medicaid Rate Evaluation Process

Development of the Strategic Rate Evaluation Process

To develop a strategic process to evaluate rates, fee schedules were grouped based on similar characteristics such as fee schedules with a greater deviation from the benchmark; or fee schedules with similar dependencies.

- Operationally, the review and development of new methodologies and rates adjustments requires significant time, funding, stakeholder discussion, policy, rulemaking, necessary administrative and programing changes in the state's Medicaid Management Information System (MMIS), and federal state plan approval from CMS.
- The Department will not be able to implement all recommendations at the same time from an operational, administrative, or a financial perspective. **By grouping fee schedules, the Department was able to develop an evaluation schedule, creating a transparent and predictable timeline for both the provider community and the Department.**

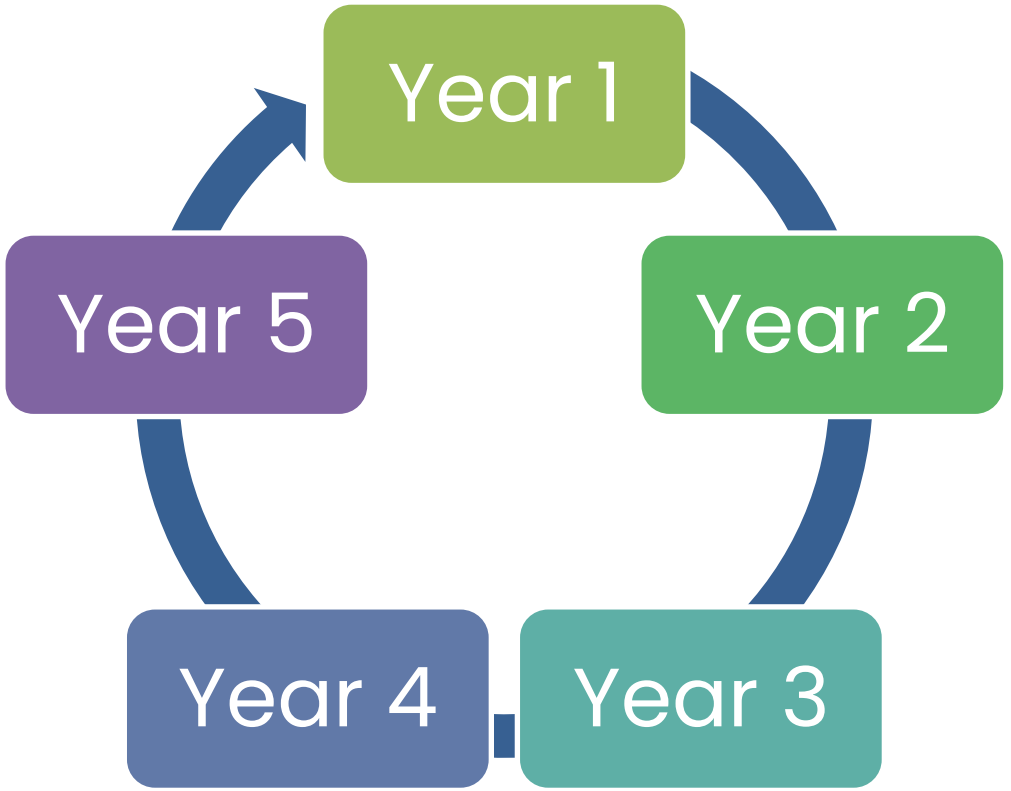
Rate Evaluation Process

Rate Evaluations will take place over a five-year period such that, by the end of the cycle, the entire Medicaid program will have been evaluated.

In each of the years, recommendations will be made for rate adjustments.

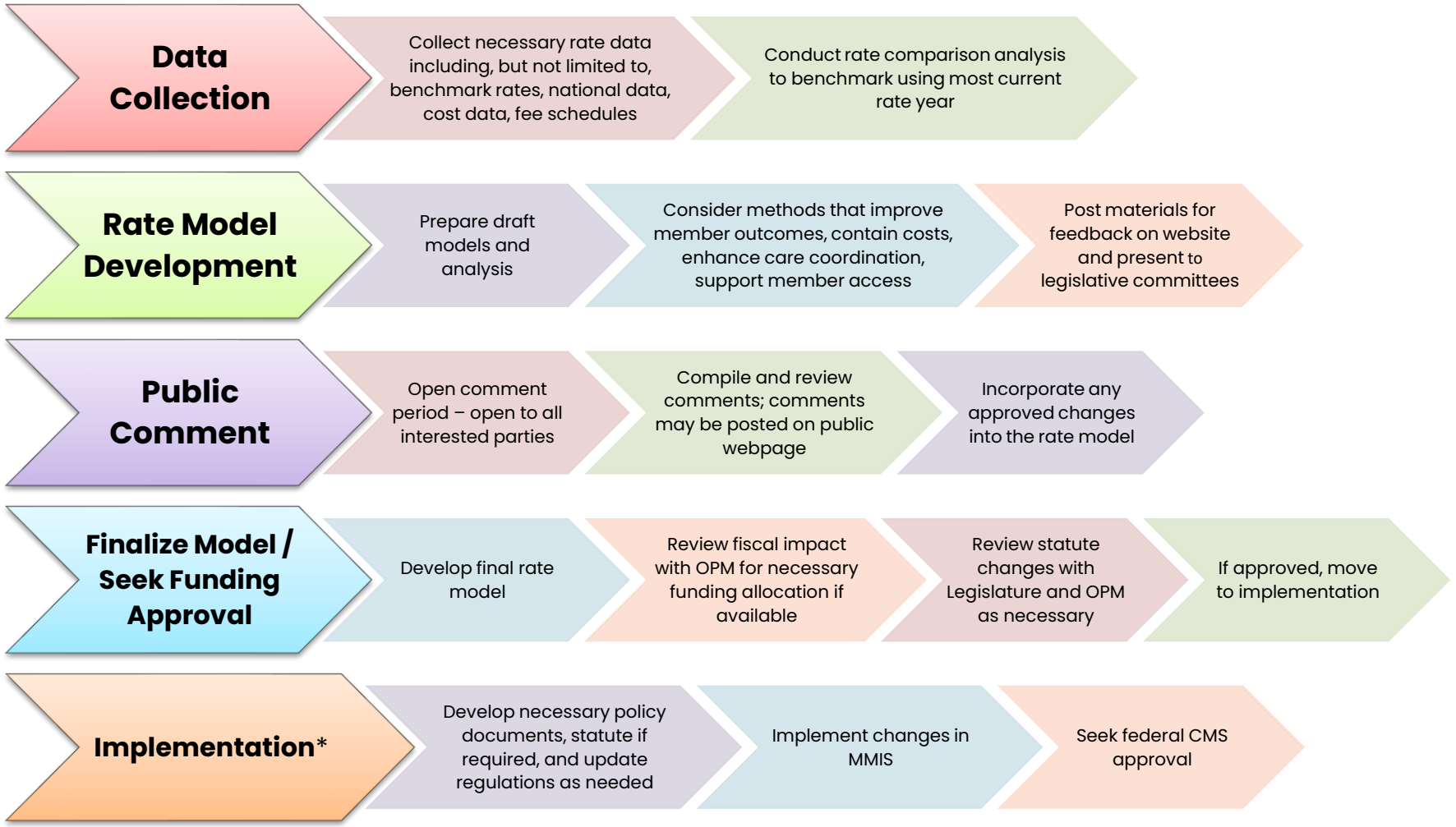
Although state budget cycles may not align with rate evaluation years, **this does not mean providers evaluated within a year are passed over for rate consideration**. The evaluation process is designed to gather recommendations at the end of the evaluation year. Recommendations are carried into the following state budget year for discussion regarding available funding for rate adjustments.

Once the end of the five-year cycle has finished, the Department will commence a new five-year cycle following the same schedule and continue such reviews every five years.



Medicaid Rate Evaluation Process

What will happen during the rate evaluation year?



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

Criteria for determining if rate increases are recommended include other factors such as:

- Evaluation of access for Medicaid members
- Provider network sustainability
- Rebalancing efforts
- Utilization trends

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

** Implementation is lengthy, typically taking 12 months or longer, since it is dependent on other organizations not within Department control.*

Service/Provider Type	FY 2026	FY 2027
Physician Fee Schedule- Primary Care	$2,500,000	$6,000,000
FQHC Rates	$5,000,000	$12,000,000
Physician Specialty/Surgery	$3,000,000	$6,000,000
Therapy Services (PT, OT, Speech)	-	$2,000,000
Family Planning	-	$1,000,000
Adult Behavioral Health	$2,000,000	$5,000,000
Child Behavioral Health	$1,000,000	$3,000,000

Rate Increase Proposals Based on Access & Outcomes

The rate study recommended that rate adjustments made outside of the rate setting cadence should be made when there is a need to support member access to services and/or to focus on improved health outcomes and policy goals for member care.

Services listed below are to be reviewed in the later years of the rate evaluation process but have been identified for interim increases for access reasons or to support policy goals and/or member outcomes.

Service/Provider Type	FY 2026	FY 2027
Adult Dental	$530,000	$1,000,000
Birth Center Facility Fees	$250,000	$600,000
Collaborative Care Model – Primary Care	-	$800,000
Collaborative Care Model – FQHC	-	$200,000
Obstetrics Pay for Performance Program (OB P4P)	$120,000	-
Chronic Disease Care Management	$500,000	$6,000,000
Long-Term Acute Care Hospital (LTACH) Rate Parity	-	$800,000

Appendix

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

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

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

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

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

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

Repeat starting with Year 1