State of Connecticut – Department of Social Services
Access Monitoring Review Plan for Connecticut's Medicaid Program

APPENDIX 2

Access Analysis for Payment Reduction Medicaid State Plan Amendments

Submitted March 31, 2017

As required by federal regulations at 42 C.F.R. §§ 447.203(b)(5)(ii)(F), 447.203(b)(6), 447.204(a), and 447.204(b), this Appendix 2 to the Access Monitoring Review Plan for Connecticut's Medicaid Program includes the Access Analyses for Medicaid State Plan Amendments (SPAs) submitted in the calendar quarter ending March 31, 2017 that reduce rates or restructure provider payments in circumstances when the changes could result in diminished access, as follows:

- SPA 17-0007 – Medical Equipment, Devices and Supplies (MEDS) Reimbursement

This Access Analysis is also included as part of the SPA submission package that the state is submitting to CMS simultaneously with this Appendix.

CT SPA 17-0007 – Medical Equipment Devices and Supplies (MEDS) Reimbursement

ACCESS ANALYSIS

Submitted March 31, 2017

Medicaid State Plan Amendment (SPA) 17-0007 proposes to reduce the rates for certain procedure codes found on the MEDS fee schedule in order to ensure continued compliance with federal law in section 1902(a)(30)(A) of the Social Security Act, which requires all state Medicaid programs to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan…as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area…."

This SPA revised the rental reimbursement fees for certain procedure codes in order to not exceed the purchase price of the item, if the item was continually rented for 10 months. This change is not likely to affect access because most providers usually purchase the durable medical equipment (DME) after 3 months of rental. Thus, this change is necessary to prevent unnecessary utilization.

This SPA decreased reimbursement amounts to certain procedure codes in order to reimburse more accurately for these services and ensure continued compliance with the requirements for economy and efficiency in accordance with section 1902(a)(30)(A) of the Social Security Act. The reimbursement changes were based on pricing data obtained from several sources, including: Medicare Rates; Other states' Medicaid rates; and Pricing research conducted by the Department.

Specifically, procedure code A6549 (gradient compression stocking/sleeve, not otherwise specified), which is a manually priced procedure code, was reduced from actual acquisition cost (AAC) plus 45% to AAC plus 25%. Procedure code S1040 (Cranial remolding orthosis pediatric rigid with soft interface material custom fabricated, includes fitting and adjustment(s)) was reduced from $2000 to $1191.16 in order to be consistent with fees paid by other states and to contain costs. In addition, the fees for several other orthoses which are custom fabricated or customized to fit a specific member by an individual with expertise were reduced by 10%. Reimbursements for off-the-shelf orthoses procedure codes that have a parallel custom-fitted version for the same item were lowered to the same reimbursement fee as the custom-fitted procedure codes. This change was implemented to improve pricing consistency among the off-the-shelf and custom-fitted orthoses procedure codes. Finally, two oxygen procedure codes (E0424 and E0439) were compared to Medicare's rural rates of $77.16 for each, as well as our

neighboring state's rates in New York, which are $100.00 for code E0424 and $72.50 for code E0439. The fees were reduced to $100.00 for each code in order to be consistent with fees paid by our neighboring state of New York.

As described below, in accordance with 42 C.F.R. § 447.204(a), prior to the submission of this SPA, the state considered the data collected and analysis performed for this service and the input from beneficiaries, providers, and other affected stakeholders regarding the potential impact of this SPA. The comment period ended on March 30, 2017. This analysis incorporates the comments received by the state. Further, in accordance with 42 C.F.R. § 447.203(b)(6), the analysis below includes an access review that is being attached to the state's Access Monitoring Review Plan and monitoring procedures to ensure ongoing monitoring of access to this service. As explained below, this analysis demonstrates that there remains sufficient access to the services affected by this SPA.

Measures and Analyses

The State looked at several measures, which demonstrate that there is sufficient access to MEDS services and determined that the proposed rate reductions would not negatively impact access to members obtaining MEDS devices and/or supplies impacted by this proposed SPA. The state has determined that this SPA complies with access requirements based on an analysis of the following measures: (1) total number of Medicaid beneficiaries; (2) number of enrolled MEDS providers; and (3) utilization by MEDS providers billing for the procedure codes impacted by the proposed changes.

Table 1 below, shows the total number of Medicaid beneficiaries by program type enrolled for calendar years (CY) 2015 through 2016.

Table 1. Total number of Medicaid Beneficiaries by Eligibility Type Calendar Years 2015 and 2016

MEDICAID ELIGIBILITY TYPE	Unduplicated Beneficiaries CY 2015	Unduplicated Beneficiaries CY 2016
HUSKY A	578,963	557,747
HUSKY C	112,387	109,912
HUSKY D	266037	273,603
Sum:	**957,387**	**941,262**

HUSKY A: children, caretaker adults, and pregnant women coverage groups.
HUSKY C: aged, blind, and disabled coverage groups.

HUSKY D: low-income adult coverage groups.

(HUSKY B is not included in this analysis because it is Connecticut's Children's Health Insurance Program, under Title 21 of the Social Security Act and is not part of Connecticut's Medicaid program.)

Table 2 below shows the count of Medical Equipment, Devices and Supplies (MEDS) providers who were enrolled by county for calendar year CY 2016. Based on the numbers below, the counties with the greatest number of Connecticut (CT) Medicaid beneficiaries are located in Fairfield, Hartford and New Haven. These same counties also have the greatest number of MEDS providers enrolled, which is expected because those are also the counties with the highest population density, as described in the state's Access Monitoring Review Plan. As indicated below, Tolland County has zero MEDS providers enrolled in that area. As a county with a lower population density than many of the other counties, access to various services is more challenging in that area for various types of services, regardless of payer. Moreover, especially because Connecticut is such a geographically compact state, Tolland County also has access to services in neighboring counties.

More generally, the state has determined that there is sufficient access to MEDS services throughout the state because supplies and DME items are routinely shipped to the beneficiaries' home, regardless of where they live, thereby limiting and in some areas eliminating the need for MEDS providers to have a physical location be available in various geographic areas of the state. Although there are certain MEDS providers that have multiple physical locations throughout the state, the majority of the MEDS providers maintain only one physical location. These single locations provide services across several counties and, in many cases, throughout the entire state. Furthermore, what is unique with MEDS providers is that the majority of supplies and DME items do not require beneficiaries to be physically present in order to receive the item. For those reasons, there is adequate access to medical equipment devices and supplies throughout the state.

Table 2: Counts of CT Medicaid Medical Equipment, Devices and Supplies (MEDS) Providers, Calendar Year 2016.

Medical Equipment, Devices and Supplies (MEDS) Providers	**Statewide MEDS Provider Count***
Provider County Description	**CY 2016**
Fairfield	156
Hartford	204
Litchfield	35
Middlesex	40
New Haven	224

New London	63
Tolland	0
Windham	23
Total:	**745**

** Data was obtained through the state's Data Warehouse based on paid claims for CY 2016.*

Utilization Analysis

Table 3 below outlines the utilization of Medical Equipment, Devices and Supplies (MEDS) procedure codes affected by the proposed reimbursement reductions in SPA 17-0007 by county.

Table 3: Utilization of Medical Equipment, Devices and Supplies (MEDS) in Calendar Year 2016.

County	Unique Recipients	# of Billing Providers	Units of Service	Paid Amount
Fairfield	4,535	122	10,843	$ 1,414,067
Hartford	6,567	134	12,337	$ 1,287,040
Litchfield	790	71	2,656	$ 177,228
Middlesex	577	60	1,229	$ 132,187
New Haven	6,312	166	14,700	$ 1,509,240
New London	1,682	75	4,118	$ 421,313
Tolland	474	45	925	$ 99,503
Windham	896	52	1,512	$ 191,384
Total	**21,833**	**725**	**48,320**	**$ 5,231,963**

The data in Table 3 above was extracted based on dates of service paid in calendar year 2016 and will serve as the baseline data for future analysis in order to determine if the rate reductions proposed under this SPA has negatively impacted access to these items. The State does not anticipate a negative impact on access to care for medical equipment, devices and supplies by SPA 17-0007.

Rate Comparison

The rate comparison tables below compare the rates proposed under this SPA with the rates reimbursed by neighboring state Medicaid programs (New York and Massachusetts). Since Medicare does not pay for several of the procedure codes that were reduced, Medicare's rates were not used in the overall comparison and instead will be shown below as necessary for specific procedure code comparisons.

Connecticut's overall reimbursement for the codes impacted by this proposed SPA was compared with New York and Massachusetts rates. Below are the average differences for each category impacted by this SPA:

Medical Surgical Supplies:

- Connecticut's rates on average are 3.89% higher than New York's
- Connecticut's rates on average are 55.26% lower than Massachusetts

Durable Medical Equipment:

- Connecticut's rates on average are 3.10% lower than New York
- Connecticut's rates on average are 129.51% lower than Mass

Prosthetic/Orthotic Devices:

- Connecticut's rates on average are 12% lower than New York
- Connecticut's rates on average are 28.85% lower than Massachusetts

When the rates for the medical surgical supplies are compared (please see Table 4) to New York's (NY) Medicaid rates, on average, New York's rates are 3.9% lower than or equal to Connecticut's (CT) proposed rates. While on average, Massachusetts' (MA) rates are 55% higher than Connecticut's proposed rates, Massachusetts' rate for the blood pressure monitor is approximately 2% lower than CT's rate. The rate for replacement batteries for the TENS unit (procedure code A4630) that is causing the average difference between CT and MA to be the greatest, shows that MA is approximately 123% higher than CT. However, it should be noted that Connecticut has only 1 DME provider billing for the TENS batteries. No other providers are submitting claims for procedure code A4630.

Additionally, while Massachusetts' rate for the administration set with small volume pneumatic nebulizer (procedure code A7005) is 44% higher than Connecticut, Connecticut's proposed rate

is 10% higher than New York's rate. Connecticut's rate is approximately 140% higher than the Medicare published rural rate of $12.64 for procedure code A7005.

Connecticut could not compare rates with the states of New York or Massachusetts for procedure code A6549 (gradient compression stocking/sleeve not otherwise specified) because these states do not cover this procedure code. However, the Department does not believe access issues will arise from lowering the actual acquisition cost from AAC plus 45% to AAC plus 25%.

Table 4. Medical/Surgical Supplies Fee Schedule Comparison to New York and Massachusetts

MEDICAL/SURGICAL SUPPLIES FEE SCHEDULE					% Difference	
Proc. Code	**Procedure Code Description**	**CT Fee**	**NY Fee**	**Mass Fee**	**NY %**	**Mass %**
A4670	Automatic Blood Pressure Monitor	$ 65.00	$ 65.00	$ 63.57	0.00%	-2.20% *
A6549	Gradient Compression Stocking/Sleeve NOS	AAC+25%	No Fee	No Fee	-	-
A7005	Administration set w/small volume pneumatic nebulizer…	$ 18.00	$ 16.19	$ 26.06	-10.06% *	44.78%
A4630	Replacement batteries for TENS unit	$ 2.50	$ 2.46	$ 5.58	-1.60% *	123.20%

**A negative percentage means that Connecticut's rate is higher than the other state's rate.*

In table 5, below, the durable medical equipment items affected by rate cuts were compared to New York and Massachusetts' rates. In the comparison, Connecticut's rates for the bedside rails, oxygen and transcutaneous electrical nerve stimulation (TENS) device are higher than New York's rates. Massachusetts' rates for these same items are much higher than Connecticut's rates. New York's rate for the nebulizer with compressor was twice the rate of Connecticut. Massachusetts rate for this same item was 91% higher. The Department did receive one comment from a DME provider pertaining to the cuts to nebulizers and blood pressure monitors. However, these changes are not likely to affect access because the rates remain sufficiently above the actual acquisition costs provided for nebulizers, which, on average, cost about $50.00. In addition, Medicare's reimbursement of $61.20 for the nebulizers (procedure code E0570) is approximately 22.53% lower than Connecticut's rate. The TENS unit (procedure code E0720) Medicare rate of $71.36 is 0.89% lower than Connecticut's rate.

The osteogenesis stimulator devices (bone growth stimulators) were between 13% and 20% lower than New York's rates. Massachusetts' rate for the bone growth stimulator not used on the spine was 2.5% higher than Connecticut's rate. The other bone growth stimulators were between

18% and 26% higher than Connecticut's rates for these same items. The Department was informed that the actual acquisition cost for these bone growth stimulator devices which was approximately $1000.00. This information demonstrated that the CT's rate was approximately 2.5 times the cost of the device and therefore, this rate reduction is necessary to maintain economy and efficiency. Published literature on the use of bone growth stimulators explains that the average duration of medical need is less than six months. Furthermore, clinical literature also shows that there is debate regarding the potential clinical benefits of some of these devices. Accordingly, these rate reductions are necessary to prevent unnecessary utilization and ensure quality services by ensuring that high rates do not inappropriately encourage excessive utilization.

In addition, an article in the Journal of Bone and Joint Surgery concluded the following: "While our pooled analysis does not show a significant impact of electromagnetic stimulation on delayed unions or non-united long-bone fractures, methodological limitations and high between-study heterogeneity leave the impact of electromagnetic stimulation on fracture-healing uncertain." Volume 90-A , Number 11, November 2008 – "Electrical Stimulation for Long-Bone Fracture-Healing: A Meta-Analysis of Randomized Controlled Trials" Brent Mollon, Vitor da Silva, Jason W. Busse, Thomas A. Einhorn and Mohit Bhandari – 2008:90:2322-2330, https://www.ncbi.nlm.nih.gov/pubmed/18978400 (emphasis added).

A different article found in the BMJ (formerly known as the British Medical Journal) summarized its conclusions as follows: "Postoperative use of low intensity pulsed ultrasound (LIPUS) after tibial fracture fixation does not accelerate radiographic healing and fails to improve functional recovery". Their study adds: "Addition of LIPUS to usual care for patients with fracture failed to accelerate radiographic healing or improve function". Busse Jason W, Bhandari Mohit, Einhorn Thomas A, Schemitsch Emil, Heckman James D et al. Re-evaluation of low intensity pulsed ultrasound in treatment of tibial fractures (TRUST): randomized clinical trial BMJ 2016; 355 :i5351 (published October 25, 2016), http://www.bmj.com/content/355/bmj.i5351 (emphasis added).

Based on this research and other relevant factors described above, the Department has determined that the reduction in the rate for the purchase of these devices is not likely to negatively affect access to medically necessary services.

Table 5. Durable Medical Equipment Fee Schedule Comparison to New York and Massachusetts

DME FEE SCHEDULE					% Difference	
Proc. Code	**Procedure Code Description**	**CT Fee**	**NY Fee**	**Mass Fee**	**NY %**	**Mass %**
E0305	Bed side rails half length	$ 114.90	$ 95.24	$143.69	-17.11%*	25.06%
E0310	Bed side rails full length	$ 119.33	$115.35	$142.32	-3.34%*	19.27%
E0424	Stationary compressed gaseous oxygen…	$ 100.00	$100.00	$ 158.51	0.00%	58.51%
E0439	Stationary liquid oxygen system rental…	$ 100.00	$ 72.50	$ 158.51	-27.50%*	58.51%
E0445	Oximeter device for measuring blood oxygen levels non-invasively	$ 202.50	$ 165.00	$ 856.30	-18.52%*	322.86%
E0570	Nebulizer with compressor	$ 79.00	$ 117.89	$ 151.01	49.23%	91.15%
E0720	Transcutaneous electrical nerve stimulation (tens) device two lead…	$ 72.01	No Fee	$328.07	-	355.59%
E0730	Transcutaneous electrical nerve stimulation (tens) device four leads …	$ 79.00	$ 76.25	$ 330.73	-3.48%*	318.65%
E0731	Form fitting conductive garment for delivery of tens or nmes…	$ 77.36	No Fee	$ 270.59	-	249.78%
E0747	Osteogenesis stimulator electrical non-invasive other than spinal application	$2,898.72	$3,300	$2,970.83	13.84%	2.49%
E0748	Osteogenesis stimulator electrical non-invasive spinal application	$2,753.19	$3,300	$3,472.45	19.86%	26.12%
E0760	Osteogenesis stimulator low intensity ultrasound non-invasive	$2,287.89	$2,700	$2,885.55	18.01%	26.12%

**A negative percentage means that Connecticut's rate is higher than the other state's rate.*

Table 6 below compares different types of orthotic braces as well as the cranial remolding orthosis. When comparing rates for the lumbar sacral orthosis, New York's Medicaid rates were 9% to 23% higher than Connecticut's rates and Massachusetts rates were between 16% and 34% higher. However, there were several off-the-shelf-lumbar orthosis (procedure codes L0641, L0643 and L0649) which had lower rates in New York's Medicaid Program. These same off-the-shelf lumbar orthosis that have a lower reimbursement fee in New York are not covered at all under the Massachusetts Medicaid Program. The Department did receive a comment from one DME provider in regards to an off-the-shelf lumbar-sacral orthosis (procedure code L0650) which was removed from the fee schedule. Procedure code L0650 was the most expensive off-the-shelf brace on the fee schedule with a reimbursement of $988.78. The Department removed

this off-the-shelf brace from the fee schedule in order to insure that our Medicaid members are being properly fitted for lumbar orthosis and not receiving an off-the-shelf brace that may not fit or work for the member. There is an equivalent lumbar sacral orthosis code that can be provided with prior authorization. However, this code will require that a provider employ an orthotic fitter, which helps ensure higher quality services are provided by making each device be specifically fitted for the unique clinical needs of each Medicaid member.

When comparing the rates for the knee orthoses, there were fluctuations in pricing by the New York Medicaid Program. Some knee orthoses had lower rates in New York when compared to Connecticut's rates (see procedure codes L1812, L1840, L1850 and L1860). Meanwhile some other knee orthosis were 10% to 34% higher. Massachusetts' rates for these same items were 21 % to 47% higher than Connecticut's rate.

Connecticut's rate for the elbow orthosis (procedure code L3760) was approximate 14% higher than New York's rate. Massachusetts' rate was 25% higher than Connecticut's rate for this same type of orthosis.

The reimbursement for the wrist, finger and hand orthosis varied in percent differences when comparisons were done between Connecticut, New York and Massachusetts. Connecticut had several braces whose rates were higher than New York's rates (L3918 and L3930). New York's reimbursement for procedure code L3924 is 123% higher than Connecticut's reimbursement of $25.23. However, Massachusetts does not cover this type of orthosis at all.

The Department received comments from an orthotic & prosthetic provider proposing that the custom items on the fee schedule not be reduced due to the level of service they provide to patients and level of documentation requirements they provide as certified orthotic and prosthetic providers. However, the Department has determined that off-the-shelf codes should not be reimbursed higher than the orthoses that requires the skilled fitting of an individual with clinical expertise. In addition, the Department was made aware of the actual acquisition cost for several of these orthosis and found that orthotic and prosthetic providers were getting paid 5 times the cost for some of these types of orthotic braces. Accordingly, these reductions are necessary to maintain economy and efficiency, reduce unnecessary utilization, and are all likely to maintain sufficient access and quality.

Based on additional analysis, including consideration of the feedback received from providers in response to this SPA, the Department plans to modify the proposed rate for procedure code L3924 from $25.23 to $56.30 so it will be the same rate as New York's rate. This same reimbursement will be provided to procedure code L3923, which is the custom fitted code version of the same type of brace.

In regards to the walking boots (procedure codes L4360 through L4387), the New York Medicaid Program does not cover walking boots at all. In addition, Massachusetts does not cover the off-the-shelf walking boots or the off-the-shelf static or dynamic ankle foot orthosis (procedure codes L4361, L4387 and L4397). Massachusetts reimbursement for the pneumatic full leg splint (code L4370) and the walking boot that is customized to fit a specific patient by an individual with expertise (code L4386) rates are 24% to 37% higher than Connecticut's rates.

Table 6. Orthotic and Prosthetic Devices Fee Schedule Comparison to New York and Massachusetts

PROSTHETIC/ORTHOTIC FEE SCHEDULE					% Difference	
Proc. Code	**Procedure Code Description**	**Current Fee**	**NY Fee**	**Mass Fee**	**NY %**	**Mass %**
L0627	Lumbar orthosis sagittal control with rigid anterior and posterior panels… customized to fit a specific patient by an individual with expertise.	$263.98	$322.98	$328.77	22.35%	24.54%
L0631	Lumbar-sacral orthosis sagittal control with rigid anterior and posterior panels… customized to fit a specific patient by an individual with expertise.	$658.72	$806.64	$821.08	22.46%	24.65%
L0635	Lumbar-sacral orthosis sagittal-coronal control lumbar flexion rigid posterior…prefabricated includes fitting and adjustment.	$642.04	$765.98	$749.45	19.30%	16.73%
L0636	Lumbar sacral orthosis sagittal-coronal control lumbar flexion rigid…custom fabricated.	$950.89	$1,036.35	$1,275.39	8.99%	34.13%
L0637	Lumbar-sacral orthosis sagittal-coronal control w/rigid anterior and posterior… customized to fit a specific patient by an individual with expertise.	$752.40	$844.13	$936.53	12.19%	24.47%
L0638	Lumbar-sacral orthosis sagittal-coronal control w/rigid anterior and posterior…custom fabricated.	$845.85	$1,036.35	$1,114.51	22.52%	31.76%
L0639	Lumbar-sacral orthosis sagittal-coronal control rigid shell(s)/panel(s) posterior… customized to fit a specific patient by an individual with expertise.	$752.40	$844.13	$936.53	12.19%	24.47%
L0640	Lumbar-sacral orthosis sagittal-coronal control rigid shell(s)/panel(s) posterior…custom fabricated.	$670.00	$822.21	$884.24	22.72%	31.98%
L0641	Lumbar orthosis sagittal control with rigid posterior panel(s) posterior ext…prefabricated, off-the-shelf.	$ 55.56	$53.80	No Fee	-3.17%*	-

L0642	Lumbar orthosis sagittal control with rigid anterior and posterior panels post… prefabricated, off-the-shelf.	$263.98	$283.76	No Fee	7.49%	-
L0643	Lumbar-sacral orthosis sagittal control with rigid posterior panel(s) posterior… prefabricated, off-the-shelf.	$115.43	$111.80	No Fee	-3.14%*	-
L0649	Lumbar-sacral orthosis sagittal-coronal control with rigid posterior frame/panel.. prefabricated, off-the-shelf.	$204.39	$197.95	No Fee	-3.15%*	-
L1812	Knee orthosis elastic with joints prefabricated off-the-shelf	$73.45	$71.04	No Fee	-3.28%*	-
L1831	Knee orthosis locking knee joint(s) positional orthosis prefabricated includes fitting and adjustment.	$188.73	$208.13	$235.40	10.28%	24.73%
L1832	Knee orthosis adjustable knee joints (unicentric or polycentric) positional… customized to fit a specific patient by an individual with expertise.	$453.26	$607.55	$608.24	34.04%	34.19%
L1834	Knee orthosis without knee joint rigid custom-fabricated.	$590.19	$595.41	$837.88	0.88%	41.97%
L1840	Knee orthosis derotation medial-lateral anterior cruciate ligament custom fabricated.	$616.81	$597.50	$789.64	-3.13%*	28.02%
L1843	Knee orthosis single upright thigh and calf with adjustable flexion and ext… customized to fit a specific patient by an individual with expertise.	$575.39	$634.53	$717.65	10.28%	24.72%
L1844	Knee orthosis single upright thigh and calf with adjustable flexion and extension…custom fabricated.	$1,065.01	$1,107.70	$1,382.61	4.01%	29.82%
L1845	Knee orthosis double upright thigh and calf with adjustable flexion and ext… customized to fit a specific patient by an individual with expertise.	$548.63	$693.00	$667.32	26.31%	21.63%
L1846	Knee orthosis double upright thigh and calf with adjustable flexion and extension…custom fabricated.	$711.88	$ 828.15	$1,049.32	16.33%	47.40%
L1847	Knee orthosis double upright with adjustable joint w/inflatable air support… customized to fit a specific patient by an individual with expertise.	$368.86	$449.98	$460.04	21.99%	24.72%
L1850	Knee orthosis swedish type prefabricated off-the-shelf.	$201.45	$185.00	$ 271.26	-8.17%*	34.65%
L1860	Knee orthosis modification of supracondylar prosthetic socket custom-fabricated.	$720.36	$617.00	$918.43	-14.35%*	27.50%
L3760	Elbow orthosis with adjustable position	$292.01	$251.34	$364.02	-13.93%*	24.66%

	locking joint(s) prefabricated includes fitting and adjustments, any type.					
L3807	Wrist hand finger orthosis without joint(s) prefabricated item that has… customized to fit a specific patient by an individual with expertise.	$146.16	$178.04	$182.02	21.81%	24.53%
L3809	Wrist hand finger orthosis without joint(s) prefabricated off-the-shelf any type.	$146.16	$157.10	No Fee	7.48%	-
L3915	Wrist hand orthosis includes one or more nontorsion joint(s) elastic bands… customized to fit a specific patient by an individual with expertise.	$310.74	$407.17	$386.92	31.03%	24.52%
L3918	Hand orthosis metacarpal fracture orthosis prefabricated off-the-shelf	$68.50	$66.38	No Fee	-3.09%*	-
L3924	Hand finger orthosis without joints may include soft interface straps prefabricated, off-the-shelf.	$25.23	$56.30	No Fee	123.15%	-
L3930	Hand finger orthosis includes one or more nontorsion joint(s) turnbuckles… prefabricated, off-the-shelf.	$52.30	$50.59	No Fee	-3.27%*	-
L4360	Walking boot pneumatic and/or vacuum with or without joints with or without interface material, prefabricated item… customized to fit a specific patient by an individual with expertise.	$211.15	No Fee	$282.88	-	33.97%
L4361	Walking boot pneumatic and/or vacuum with or without joints with or without interface material, prefabricated off-the-shelf.	$201.15	No Fee	No Fee	-	-
L4370	Pneumatic full leg splint prefabricated off-the-shelf	$140.59	No Fee	$192.87	-	37.19%
L4386	Walking boot non-pneumatic with or without joints with or without interface material, prefabricated item that has… customized to fit a specific patient by an individual with expertise.	$102.38	No Fee	$126.81	-	23.86%
L4387	Walking boot non-pneumatic with or without joints with or without interface material, prefabricated off-the-shelf.	$102.38	No Fee	No Fee	-	-
L4397	Static or dynamic ankle foot orthosis including soft interface material adjustable for fit, for positioning, may… prefabricated, off-the-shelf.	$109.38	$115.83	No Fee	5.90%	-
S1040	Cranial remolding orthosis pediatric rigid with soft interface material custom fabricated, includes fitting and	$1,191.16	$1,105.89	$1,540.95	-7.16%*	29.37%

	adjustment(s)					
TOTAL					12.06%	28.85%

**A negative percentage means that Connecticut's rate is higher than the other state's rate.*

The Department compared rates from other neighboring states to determine the proposed rate for procedure code S1040 (cranial remolding orthosis, pediatric, rigid, with soft interface material, custom fabricated, includes fitting and adjustments). Connecticut's rate of $1191.16, which was calculated based on the average rate reimbursed by the states listed in Table 7 below, is slightly higher than New York's rate of $1105.89. The Department did receive comments from different orthotic and prosthetic providers. These providers presented the argument that a 40% reduction would create undue burden and hardship on providers of cranial remolding orthoses, ultimately leading to access to care issues for Medicaid beneficiaries who are seeking cost effective, non-surgical procedures to treat infant plagiocephaly. The Department also received comments from pediatricians and physical therapists in which they argued that the proposed decrease in Connecticut Medicaid reimbursement for cranial remolding orthoses will limit the number of cranial orthosis providers in Connecticut who accept Medicaid patients. It will also fail to reimburse dedicated medical professionals in a reasonable manner for this time- and labor-intensive treatment program with the most optimal and effective Class II medical devices that these infants require.

In addition, several parents submitted comments on how their infants benefitted by using a cranial helmet for 3 months to correct plagiocephaly and how her baby's head was reshaped to a more rounded, more normal appearance.

The Department is reviewing the comments and other feedback from providers and other stakeholders. Based on the Department's review thus far, it has determined that due to the following clinical evidence, the reductions are necessary to maintain economy, efficiency, and quality, while maintaining sufficient access to medically necessary services. In particular, a research study in the BMJ, whose objective was to determine the effectiveness of helmet therapy for positional skull deformation compared with the natural course of the condition in infants aged 5-6 months, resulted in "the change score for both plagiocephaly and brachycephaly being equal between the helmet therapy and natural course groups". The study's conclusion states the following: "Based on the equal effectiveness of helmet therapy and skull deformation following its natural course, high prevalence of side effects, and high costs associated with helmet therapy, we discourage the use of a helmet as a standard treatment for healthy infants with moderate to severe skull deformation". Renske M van Wijk, Leo A van Vlimmeren, Catharina G M Groothuis-Oudshoorn, Catharina P B Van der Ploeg, Maarten J IJzerman, Magda M Boere-Boonekamp, Helmet Therapy in Infants with Positional Skull Deformation: Randomized Controlled Trial. BMJ 2014; 348: g2741, http://www.bmj.com/content/348/bmj.g2741. For all

of those reasons, the reductions are necessary to maintain economy, efficiency, and quality—while maintaining sufficient access to medically necessary services.

Table 7. Cranial Remolding Orthosis Comparison to Several Other States

S1040 - Cranial Remodeling Orthoses

Connecticut	**$ 1,191.16**
New York	$ 1,105.89
Maine	$ 850.00
Massachusetts	$ 1,540.95
Michigan	$ 904.40
Minnesota	$ 1,153.44
Ohio	$ 2,000.00
Oregon	$ 476.19
Rhode Island	no fee
Vermont	$ 2,300.00
Washington State	$ 413.00

Public Process

Medical Equipment, Devices and Supplies (MEDS) providers and the public were advised of the proposed SPA via the public notice published in the Connecticut Law Journal (as indicated above, SPA 17-0007 previously designated as SPA 17-M), which is the state's official register. The public notice and proposed SPA page were also posted to the Department's website, http://www.ct.gov/dss, select "Publications", then select "Updates". Notice was also sent through a provider bulletin that was sent electronically to MEDS providers and published on the Connecticut Medical Assistance Program website. In addition to providers, who automatically receive relevant bulletins, any interested individual can sign up to receive provider bulletins electronically. The State received various comments from DME providers, clinicians, and parents of Medicaid members about the proposed rate reductions. The State is in the process of preparing responses to the comments received. The State will continue to monitor access as

required and consider implementation of changes if necessary to counterbalance any demonstrated access to care issues that arise as a result of this proposed SPA.

Beneficiaries and the public have the ability to continue to raise access concerns both directly to the Department and also to the Department's administrative services organization (ASO). The ASO tracks and resolves all access-related issues on a quarterly basis to ensure network adequacy.

Monitoring Procedures and Potential Modifications / Corrective Action

Beneficiaries and providers may contact the administrative services organizations (ASO) to raise access related issues. If access issues are raised, the Department will help the ASO address and resolve the access issue. Providers also contact the Department directly with questions pertaining to billing issues or concerns regarding fees. If the Department receives feedback, it is promptly reviewed to determine appropriate measures to ensure continued access to care for the specific services.

In addition to these established monitoring procedures, the State is implementing monitoring procedures specific to ensuring compliance with 42 C.F.R. § 447.203(6)(ii). These procedures will include an annual review of unduplicated beneficiaries of MEDS services, utilization of procedure codes affected by the reimbursement changes, and the number of enrolled MEDS providers. This data will be compared with baseline data pulled for calendar year 2016 to analyze increases or decreases in the number of beneficiaries receiving services, the overall utilization of services and to assess changes in the number of enrolled MEDS providers. Based on the results of the analyses and assessment of ongoing beneficiary and provider feedback (consistent with § 447.203(b)(7)), the State will determine whether or not the proposed rate reduction is demonstrating a negative impact on access to certain MEDS procedure codes. If the State determines that the proposed SPA is resulting in a deficiency in access to care or inadequate access, the State will develop and submit a corrective action plan with specific steps and timelines to remedy the deficiencies.

Conclusion

As described above, the Department has carefully considered all of the relevant data regarding utilization, provider network, rate comparisons, and other relevant factors in determining to submit this SPA. Based on that analysis, the Department has also determined that there remains sufficient access to these services and that such access is expected to continue after implementation of this SPA.