STATE OF CONNECTICUT HOSPITAL PAYMENT MODERNIZATION

TRANSITION TO OUTPATIENT HOSPITAL AMBULATORY PAYMENT CLASSIFICATION

May 26, 2016

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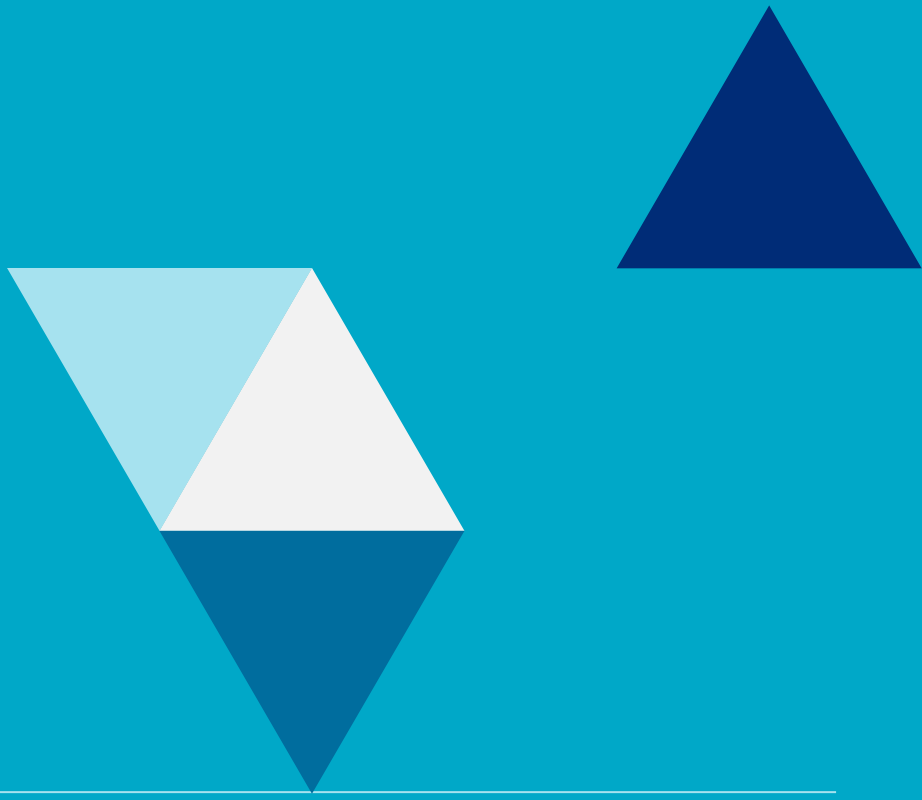
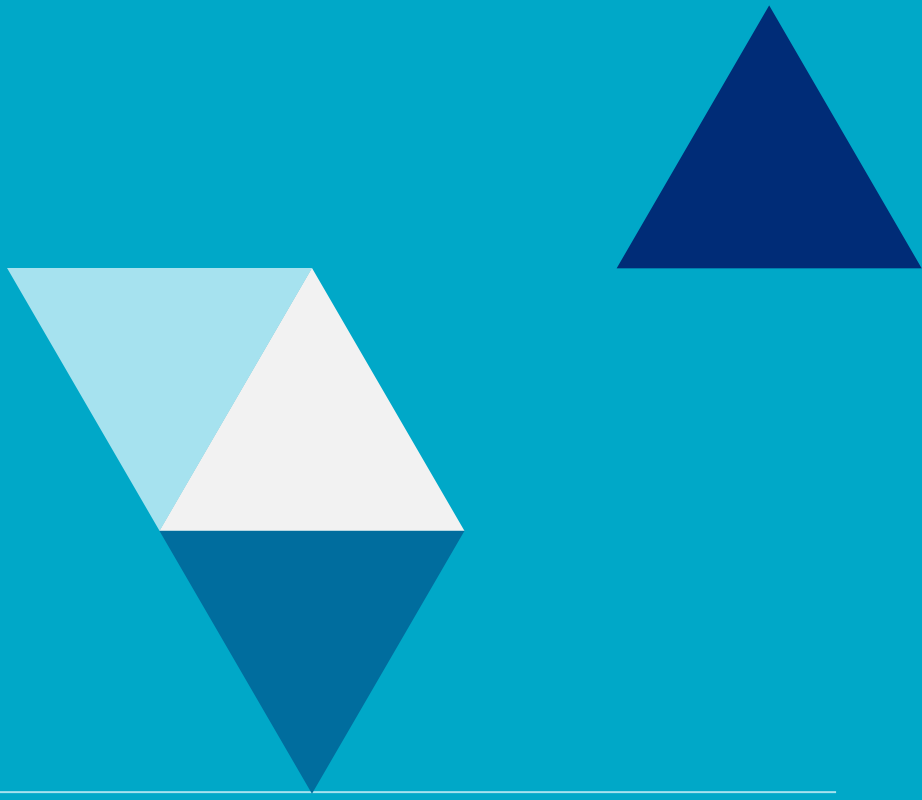
AGENDA

- Welcome and Introduction
- Data Overview
- Data Modeling
- Conversion Factor and Fiscal Impact
- Questions and Answers
- Next Steps and Resources

INTRODUCTION



DATA OVERVIEW



DATA OVERVIEW
OUTPATIENT CLAIMS

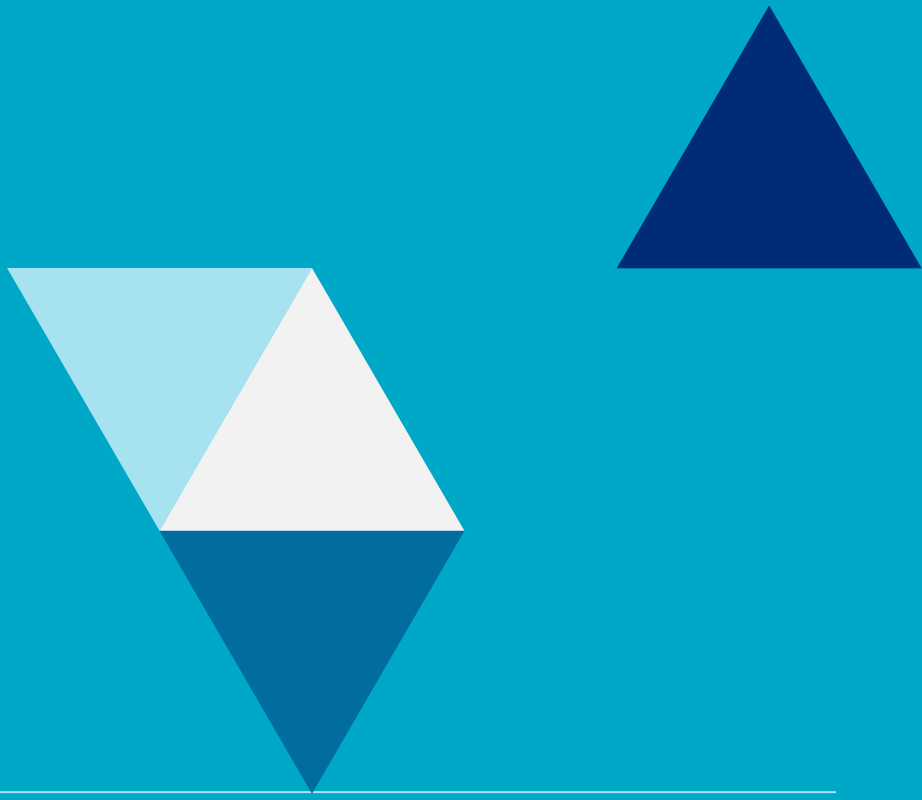
- Dates of Services from May 1, 2014 through December 31, 2014.
- Paid through April 10, 2015.
- After February 2015 Mass Adjustments applied.
- Excludes Medicare Crossovers.
- Basis: Allowed Payments.
- Excludes revenue center codes (RCCs) 960-989 which represent professional services that will no longer be billed as an outpatient hospital service.

DATA OVERVIEW
ANALYTICAL DATA SET PURPOSE

- Analytical Data Set Needs:
  - Goal — large, clean, accurate data set for analysis.
  - Used to calibrate conversion factor.
  - Not necessary — complete accounting for every claim:
    - Future system must do this.
  - Using inappropriate or incomplete data can bias analysis.

- Future Payment System Needs:
  - Accurate and appropriate conversion factor.
  - Ability to handle every claim.

DATA MODELING



DATA MODELING
STEP 1 — INITIAL DATA EXCLUSIONS

- Removed services identified as Policy Exclusions*:
  - Therapy Codes: RCCs 420-449
  - Vaccine Administration: RCC 771
  - Extended Day Treatment: RCC 907
  - Intensive Outpatient Program: RCCs 905, 906
  - Partial Hospitalization Program: RCC 913
  - Provider-Specific Programs

** Other Policy Exclusions are handled in a later step.*

DATA MODELING
STEP 2 — APC GROUPING

- Grouped claims with Ambulatory Payment Classification (APC) grouper effective January 1, 2014.
- Initial run resulted in approximately 53% of line items with at least one edit.
- Edits and Billing Issues Report was developed to determine appropriate handling of edits and identify proposed billing changes.
- All claim details categorized as “Fix” were adjusted as described in the Edits and Billing Issues Report and rerun through the 2014 APC grouper software several more times to resolve as many edits as possible.
- After data fixes were applied, approximately 5% of line items still had an edit.

DATA MODELING

STEP 3 — EDITS AND BILLING ISSUES*

Edit Code	Edit Description	Category	Claim Issue	Data Handling	Proposed Provider Billing Changes	Detail Lines
0021	OCE — Medical visit on same day as a type T or S procedure without modifier -25 (significant separate E&M service).	Fix	A clinic or emergency department visit (Status Indicator V) has been reported, without a modifier -25, on the same date of service as a significant procedure (Status Indicator S or T).	Added modifier 25 to all line items and sent the modified claim through the grouper. After secondary grouping, any line item with an APC Payable Status Indicator that still had an edit was moved to the Excluded table. Otherwise, edit ignored.	Require providers to follow Medicare billing requirements related to E&M codes.	907
0027	OCE — Only incidental services reported.	Fix	Only incidental services reported.	Added modifier L1 to all line items and sent the modified claim through the grouper. After secondary grouping, any line item with an APC Payable Status Indicator that still had an edit was moved to the Excluded table. Otherwise, edit ignored.	Require providers to follow Medicare billing requirements related to lab services.	9,391
0028	OCE — Code not recognized by Medicare.	Fix	Procedure is not a payable APC procedure. Primarily the procedure codes were behavioral health, pharmacy, E&M codes and lab codes.	Assigned the appropriate E&M codes and sent the modified claim through the grouper. After secondary grouping, edit ignored.	Require providers to follow Medicare billing requirements related to E&M codes.	32,467
0040	OCE — NCCI Edit — Code 2 of a code pair with 'XXXXX' that would be allowed if an appropriate NCCI modifier were present.	Fix	For the same date of service, a HCPCS code pair has been reported that should not be reported together. The code pairs are defined by the OPPS code set of the NCCI. A valid NCCI modifier will suppress this edit and should be used if the documentation supports it.	Added modifier 59 to all line items. After secondary grouping, edit ignored.	Require providers to follow Medicare billing requirements related to NCCI limitations.	27,533
0047	OCE — Incidental procedure not separately reimbursed.	Fix	All the line items reported have either been denied, rejected or packaged. This is a line item edit whereas 0027 is a header edit.	Added modifier L1 to all line items and sent the modified claim through the grouper. After secondary grouping, any line item with an APC Payable Status Indicator that still had an edit was moved to the Excluded table. Otherwise, edit ignored.	Require providers to follow Medicare billing requirements, related to packaged services, particularly laboratory services.	39,209
0048	OCE — Revenue Code "XXXX" requires HCPCS code on same line.	Fix	HCPCS code was blank on a claim detail where the RCC requires a HCPCS.	If RCC = 274, 470, 471, 510, 634, or 722 then moved line item to Excluded table. If RCC = 636 or 637 then moved to APC Payable table and change Status Indicator to "N".	Follow CT Medicaid guidelines related to RCC procedure code billing.	116,172
0058	OCE — G0379 only allowed with G0378.	Fix	G0379 is only allowed with G0378. G0379 indicates to Medicare that the patient arrived as a direct admit, but it does not count as the first hour. G0378 tells Medicare how long the patient stayed in observation.	Added a new line with G0378 and sent the modified claim through the grouper. After secondary grouping any APC Payable line item that still had an edit was moved to the Excluded table. Otherwise, edit ignored.	Require providers to follow Medicare billing requirements related to observations.	-
0074	OCE — Units of service greater than one is inappropriate for bilateral procedure reported with modifier 50.	Fix	A HCPCS that CMS has identified as being conditionally bilateral or independently bilateral has been reported with modifier -50 and with more than one unit of service on the same line.	Changed the number of allowed units to equal 1.	Require providers to follow Medicare billing requirements related to units of service.	-

** Table represents a sample from the full report. Please see issue paper for full report.*

DATA MODELING
STEP 3 — EDITS AND BILLING ISSUES (CONT'D)

- For any line item that had any one of the following edits, the entire claim was moved to the Excluded Table:
  - 0006, 0017, 0042, 0043, 0071, 0073, 0077, 0087, 0044, 0082, 0084, 0018, 0045, 0049
- Edits were resolved in the following order:
  - 0027, 0047, 0021, 0040, 0020, 0076, 0028, 0062, 0058, 0074
- For any line item that had any one of the following edits, the edit was ignored and was assigned to either the APC Payable Table or the Not APC Payable Table based on the assigned status indicator:
  - 0072, 0012, 0009, 0050, 0061, 0066

DATA MODELING
STEP 4 — DATA ADJUSTMENTS

- Adjusted Allowed Payments:
  - Reflected policy changes:

Data Modeling Adjustments for New Fixed Fees

Service	Criteria	Adjusted Allowed Amount
Chest X-Ray	CPT 71010, 71015, 71020, 71021, 71022, 71030, 71035	$ 28.90
Screening Mammography	CPT 77052, 77057, G0202	$ 117.91
Unlisted procedure, dental alveolar structures	CPT 41899*	$ 2,000.00

** Maximum units allowed for this code is 1.*

  - Removed Person-Centered Medical Home (PCMH) payments for two providers.
  - Adjusted for provider rate changes for two providers.

DATA MODELING
STEP 4 — DATA ADJUSTMENTS (CONT'D)

- Adjusted Allowed Units:
  - Currently, units are not used to determine Medicaid allowed payment. The MMIS does very little editing on the units, which in turn resulted in submitted units being unreliable for calculating APC payments.
  - If the Medicare maximum allowed units = 0, then adj_units = allowed units (from claim), otherwise adj_units = min(Medicare maximum allowed units, allowed units).
  - Medicare maximum allowed units is based on the Medicare Outpatient Hospital services Medically Unlikely Edit Values.

DATA MODELING
STEP 5 — INITIAL DATA TABLES

The following logic was used to create the initial tables. Additional moving of BH and other line items occurred later in the process and is described later to reflect when they were made during the modeling process.

APC Payable Table

- Overall claim disposition is 0 or 1 (only edits, if any, are line item denial/rejection).
- Status indicator is: G, H, J1, N, P, Q1, Q2, Q3, R, S, T, U, V, X.
- If detail line has one of the edits below and an assigned status indicator (SI) from the list above, then the line will be placed in the APC Payable Table: 0072, 0012, 0009, 0050, 0061, 0066.

Not APC Payable Table

- Overall claim disposition is 0 or 1 (only edits, if any, are line item denial/rejection).
- Status indicator is: A, B, C, D, E, F, K, L, M, W, Y, Z.
- If detail line has one of the edits below and an assigned SI from the list above, then the line will be placed in the Not APC Payable Table: 0072, 0012, 0009, 0050, 0061, 0066.

STEP 5 — INITIAL DATA TABLES (CONT'D)

Policy Exclusions Table

- Policy Exclusions described earlier.
- See the APC Policy Exclusions issue paper for additional details.

Excluded Table

- Overall claim disposition is greater than 1.
- Lines with the following edits were moved to the Excluded Table — 0006, 0017, 0018, 0042, 0043, 0044, 0045, 0049, 0071, 0073, 0077, 0082, 0084,0087.
- Any line with the following HCPCS were moved to the Excluded Table — 0159T, 0226T, 0227T, 0232T, 0249T, 0262T, 0275T, 0291T, 0319T, 0336T.
- Any lines that were identified as non-covered service on the Connecticut Addendum B.

DATA MODELING
INITIAL DATA TABLES — SUMMARY*

	APC Payable	Not APC Payable	Excluded
Overall Disposition	0 or 1	0 or 1	>1
SI	G, H, J1, N, P, Q1, Q2, Q3, R, S, T, U, V, X	A, B, C, D, E, F, K, L, M, W, Y, Z	
Edits	0072, 0012, 0009, 0050, 0061, 0066	0072, 0012, 0009, 0050, 0061, 0066	0006, 0017, 0018, 0042, 0043, 0044, 0045, 0049, 0071, 0073, 0077, 0082, 0084,0087
HCPCS			0159T, 0226T, 0227T, 0232T, 0249T, 0262T, 0275T, 0291T, 0319T, 0336T
Other			Non-covered service on Connecticut Addendum B

** Policy Exclusions are based on RCC and are not included in above summary.*

DATA MODELING
STEP 6 — ADDITIONAL ADJUSTMENTS

- Moved provider-specific programs to the Policy Exclusions Table.
- Moved all line items with RCC 900, 901, 914, 915, 916, 918, 919 to a new table called Routine Behavioral Health Table*.
- For any claim that had a line with modifier 73 or 74, the entire claim was moved to the Excluded Table. Lines with modifier 73 or 74 are discontinued procedures and are not covered under Medicaid policy.
- For any line item that had an RCC of 636 or 637 with a blank HCPCS, the line item was moved to the APC Payable Table and SI was changed to “N”.
- Moved any line item with edit 0053 to the Excluded Table.
- Moved any line item with SI = G, Q1, Q2, Q3 to the Excluded Table.

** BH is also considered an APC Policy Exclusion.*

DATA MODELING
STEP 6 — ADDITIONAL ADJUSTMENTS (CONT'D)

- For any line item that had an APC Payable status indicator and an edit of 0021, 0027, 0047 or 0058, the line item was moved from the APC Table to the Excluded Table.
- For any line item that had an APC Payable status indicator and multiple edits on the line, the line item was moved to the Excluded Table.
- For any line item that had an RCC of 274, 470, 471, 510, 634, or 722 with a blank HCPCS, the line item was moved to the Excluded Table.

DATA MODELING
STEP 7 — FINAL DATA TABLES

APC Payable Table
- Line items with the following status indicators remained: N, R, S, T, U, V, X except those line items that met criteria to be excluded.

Not APC Payable Table
- Line items with the following status indicators remained: A, B, C, E, F, K, L, M, Y except those line items that met criteria to be excluded.

Policy Exclusions Table
- Line items with the following RCCs: 420-449, 771, 905, 906, 907, 913.
- Provider-specific programs.

Routine Behavioral Health Table
- Line items with the following RCCs: 900, 901, 914, 915, 916, 918, 919.

Note: The status indicators listed above reflect actual data and differ from the criteria where a status indicator was not present in the data.

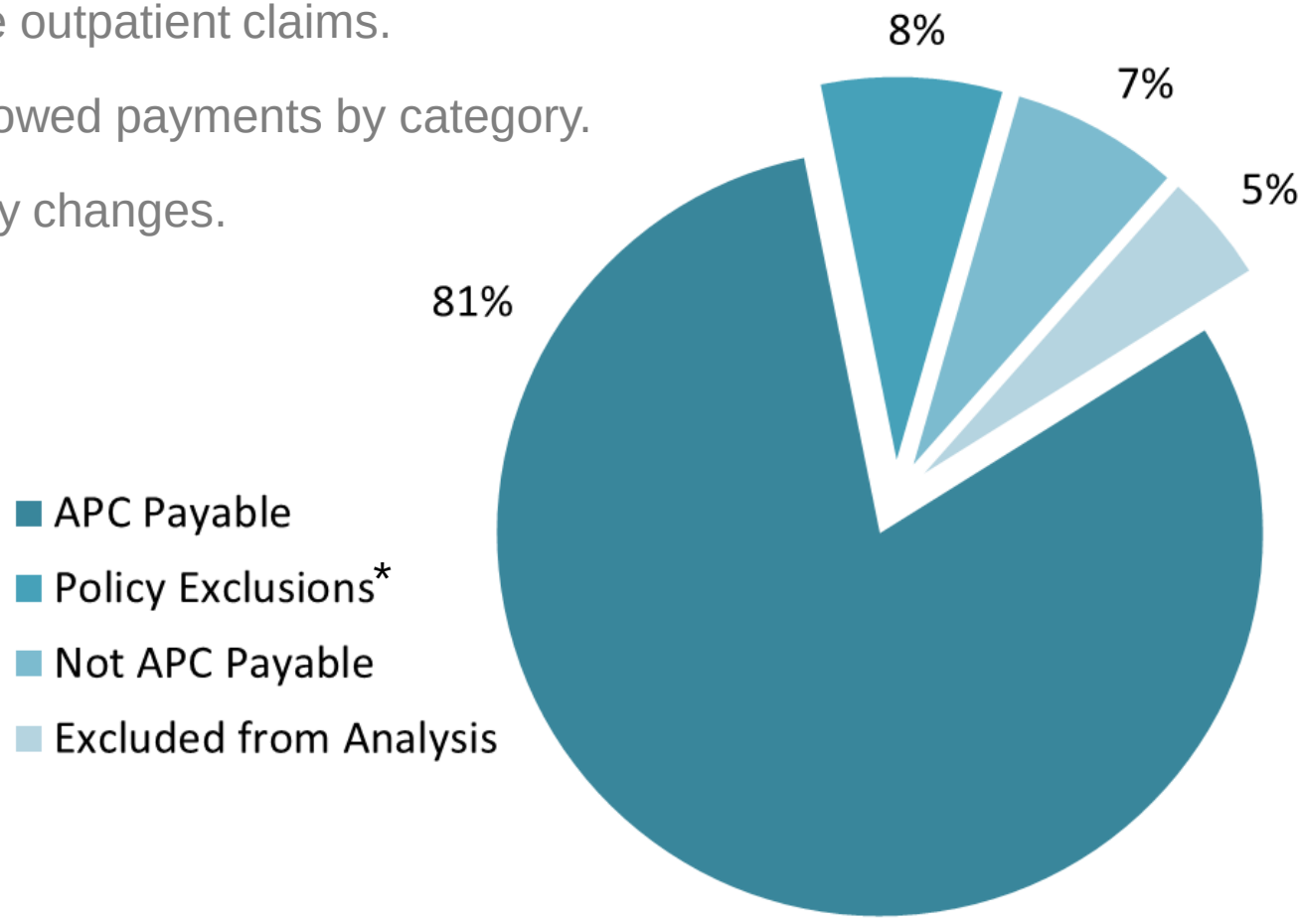
DATA MODELING
STEP 7 — FINAL DATA TABLES (CONT'D)

Excluded Table

- For any line item that had one of the following edits, the entire claim was moved to the Excluded Table: 0006, 0017, 0018, 0042, 0043, 0044, 0045, 0049, 0053, 0071, 0073, 0077, 0082, 0084, 0087.
- For any HCPCS code that was identified as a non-covered service on the Connecticut Addendum B, only the line item was moved to the Excluded Table.
- For any claim that had a line item with modifier 73 or 74, the entire claim was moved to the Excluded Table.
- For any line item that had an RCC of 274, 470, 471, 510, 634 or 722 with a blank HCPCS code, the line item was moved to the Excluded Table.
- For any line item that had an APC Payable status indicator and an edit of 0021, 0027, 0047 or 0058, the line item was moved to the Excluded Table.
- For any line item that had a status indicator of G, Q1, Q2 or Q3, the line item was moved to the Excluded Table.
- For any line item that had an APC Payable status indicator and multiple edits on the line, the line item was moved to the Excluded Table.

DATA MODELING
ANALYTICAL DATA SET

- Universe of future outpatient claims.
- Percentage of allowed payments by category.
- Adjusted for policy changes.

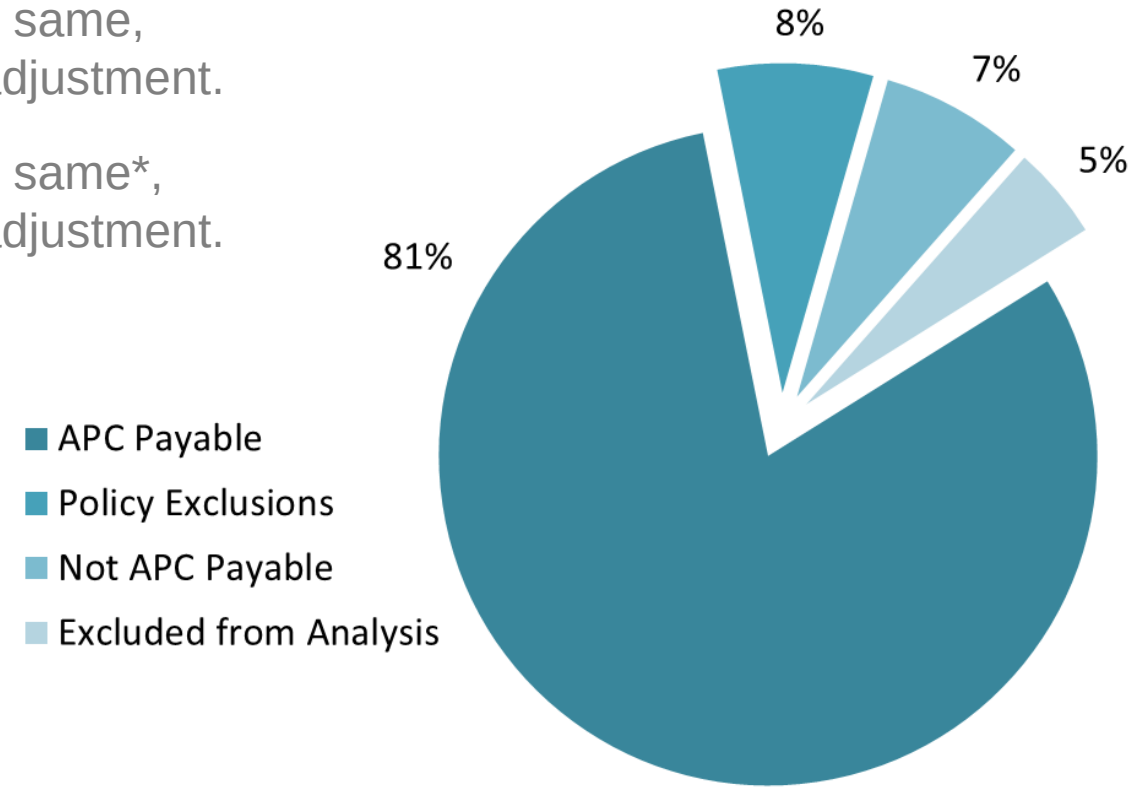


** Includes BH services.*

CONVERSION FACTOR AND FISCAL IMPACT

CONVERSION FACTOR AND FISCAL IMPACT
FISCAL IMPACT

- APC Payable — used to solve for the conversion factor.
- Policy Exclusions — pay the same, or have a calculated target adjustment.
- Not APC Payable — pay the same*, or have a calculated target adjustment.



** ~0.1% of allowed payments were not repriced and assumed at previous amount.*

CONVERSION FACTOR AND FISCAL IMPACT
TARGET ADJUSTMENTS

- Unbundling of Professional Billing for RCC 456, 51x, and other RCCs:
  - Estimated newly generated professional payments using current professional fee schedules (~$13 million).
  - These payments were removed from APC Payable Target.
- Changes in Payment for Routine BH:
  - The impact of moving from RCC payment to the Behavioral Health Clinic Fee Schedule is estimated to be an increase of approximately $543,000 in aggregate.
  - This increase in BH payments translates to a reduction to the APC Payable Target.
- Changes in Payment for Prescription Drugs with Status Indicator K:
  - The decision to use the Medicare fees for these claims resulted in a reduction in payments of just over $2 million in aggregate.
  - This amount was added to the APC Payable Target.

CONVERSION FACTOR AND FISCAL IMPACT CALCULATION PROCESS

- The conversion factor was calculated using an iterative simulation process where the APC claims were re-priced at different conversion factors until the estimated APC Payable payments were approximately equal to the Adjusted APC Payable Target.
- Difficult to “back in” to the conversion factor using a spreadsheet model because:
  - Outlier thresholds depend on the conversion factor.
  - File size too big for Excel.
- Conversion factor calculation example:
  - Step 1: Start with a conversion factor and calculate an APC payment for each APC Payable line item.
  - Step 2: Sum all the calculated APC payments and compare to the Adjusted APC Payable Budget Target.
  - Step 3: Is difference within tolerance? If yes, stop. If no, then choose another conversion factor and repeat steps 1–3 until difference is within tolerance.

CONVERSION FACTOR AND FISCAL IMPACT
SUMMARY OF CHANGES

- BH:
  - Group Therapy (RCC 915):
    - Previous payment levels.
    - Will pay based on procedure code.
  - Psychiatric Testing (RCC 918):
    - No change in payment for Chronic Disease Hospitals.
- ECC:
  - Inconsistency in previous model was removed.
- Rx Status Indicator K:
  - Decision to pay based on Medicare fees.
  - Added to Target Adjustment.
- Diagnostic Mammograms:
  - Converting from ratio of cost to charges to fixed fee.

CONVERSION FACTOR RESULTS

- Conversion Factor*:
  - Changed from $73.60 to $74.14
- 2016 Medicare Conversion Factor*:
  - $73.929

** Conversion factors shown before wage index adjustment applied.*

QUESTIONS & ANSWERS

QUESTIONS & ANSWERS
BUDGET NEUTRALITY

- **Is the implementation of APCs intended to be budget neutral?**
  - Revenue neutral in aggregate, in spirit, and in calculation methods:
    - But no formal accounting treatment.
    - Simply more detail, less consistent starting point, differing approaches and varying data quality (why we are modernizing — when you fix something, it does not stay the same).
    - We think results are valid in aggregate, lesser confidence on hospital-specific (data, data, data).
    - By using Medicare methods as much as possible — external validation is possible and important (unlike Diagnosis Related Groups modeling).
    - Consistent with inpatient — no inflation factors have been included, and as a fee schedule, acuity increases are automatically realized.
    - Uncontrolled inflation is one of the undesirable aspects of current outpatient system.
  - System will be monitored to ensure original assumptions are met.

QUESTIONS & ANSWERS
PHASE-IN

- **Does the implementation of APCs envision a phase-in from hospital-specific to statewide?**
  - Project assumes full statewide implementation on July 1, 2016.
  - One conversion factor with wage index adjustment, except Connecticut Children's Medical Center will be treated as a separate peer group.
  - Concerns regarding lack of standardization in hospital-specific billing practices.
  - Number of adjustments required to data.
  - Policy goal: Future system will pay all hospitals the same amount for the same service.

QUESTIONS & ANSWERS
WAGE INDEX ADJUSTMENTS

- **Will the conversion factor be wage adjusted?**
  - Yes, original Medicare wage indices **prior** to reclassification will be applied to the statewide conversion factor.
- **Why are wage indices applied when Connecticut is a small area state?**
  - Project has a guiding principle to follow Medicare as closely as possible.
  - Methods show a variation in wages by geography.

QUESTIONS & ANSWERS
BEHAVIORAL HEALTH

- **Will BH services be excluded from the APC methodology?**
  - Yes, RCCs 90x, 91x and 953 will all be excluded from the APC methodology.
- **Will BH services continue to be paid using the BH revenue center code rates?**
  - Some BH services will continue to use the existing BH RCC rates. For example, Group Therapy, Partial Hospitalization Program, and the Intensive Outpatient Program. For a complete list see the BH issue paper.
  - Effective July 1, 2016, all BH services reimbursement will be based on procedure codes.
  - In the instances where the rate is not changing, the RCC rate has been loaded to the fee schedule under the appropriate rate type and procedure code.
- **What fee schedules will be used for BH services?**
  - BH outpatient services will be paid according the fees on the BH Clinic-Outpatient fee schedule. Specific rate types have been designated for Outpatient Mental Health, Outpatient Enhanced Clinic and Outpatient Chronic Disease.

QUESTIONS & ANSWERS
PROFESSIONAL SERVICES

- **How will outpatient professional services be reimbursed?**
  - Most professional services delivered by a hospital based provider are reimbursed based on the physician fee schedule. The current physician fee schedules can be accessed and downloaded from Connecticut Medical Assistance Program's web site, www.ctdssmap.com.
- **Can emergency room practices bill directly — not through the hospital?**
  - Yes, effective July 1, 2016, providers will be required to bill professional services provided in the emergency department directly to the MMIS using the professional claim.
  - This includes professional services in the emergency room prior to an inpatient admission.
- **Which professionals should not bill directly on the professional claim form?**
  - The detailed changes to professional billing related to outpatient services can be found in provider bulletin PB 2016-06.

QUESTIONS & ANSWERS
COST TO CHARGE RATIOS

- **What cost to charge ratios were used for determining the current payment amounts in the Fiscal Impact Model?**
  - The Medicaid allowed amount from the analytical data set was used in the determination of current payment amounts. Claims from May 1, 2014 through June 30, 2014 are based on percent of charges from the FFY11 cost report and claims from July 1, 2014 through December 31, 2014 are based on percent of charges from the FFY12 cost report.
- **What cost to charge ratios were used for determining outlier payments in the conversion factor calculation?**
  - For each hospital an overall outpatient cost to charge ratio was calculated using information from the Medicare cost report with a fiscal year ending in 2014. The charge and cost data was obtained from Worksheet D, Part V.
- **Will cost to charge ratios be used in the future payment system?**
  - The new system uses fixed fees and only utilizes cost to charge ratios for outliers. Cost to charge ratios will be updated annually.

QUESTIONS & ANSWERS
OTHER FINANCIAL TOPICS

- **Does the APC conversion factor calculation include an adjustment for disproportionate share hospitals?**
  - No.
- **Does the APC conversion factor calculation include an adjustment for graduate medical education?**
  - No.
- **Was the Hospital Tax used in the development the APC conversion factor?**
  - No.

QUESTIONS & ANSWERS
APC PAYMENT CALCULATION

- **Will DSS provide a Connecticut-specific Addendum B?**
  - Yes, DSS has published Connecticut Addendum B and an associated issue paper. Since this publication, updates have been made and the latest version will be published on May 27, 2016.
    - Prior to APC implementation, this document can be found at http://www.ct.gov/dss/cwp/view.asp?a=4598&q=571050.
    - After APC implementation, this document will be located on the Fee Schedule page on Implementation at www.ctdssmap.com.
- **How would a hospital calculate its specific APC payments?**
  - Hospitals would need to use the APC grouper software along with their wage index, the statewide conversion factor, APC relative weights, the outlier parameters and Connecticut Addendum B.
- **Is there an APC payment example?**
  - Yes, Attachment A of the Outpatient Outliers issue paper provides an APC payment example.
  - Additional examples are provided in HPE's provider training.

QUESTIONS & ANSWERS
APC PAYMENT POLICIES

- **Is DSS following Medicare's bundling policy for SI = "N"?**
  - DSS is following Medicare's bundling process and policy. The few exceptions where a procedure code assigned a SI = "N" that is not bundled are related to services excluded from APCs such as BH and vaccines or services not covered by DSS.
- **Where are the Medicaid policies for SIs J1, Q1, Q2, Q3, S, T and V that state why the APCs identified on Addendum B are not reimbursed by Medicaid?**
  - The policies for APCs that are identified by Medicare in Addendum B but not reimbursed by Medicaid will be found in the updated Outpatient State Regulations.
  - Sec. 17b-262-973 addresses Services Not Covered and a new section Sec. 17b-262-970 addresses Services Covered and Limitations.
  - There are some specific procedures codes not payable in Medicaid but the service is covered and must be billed under a different procedure code.

QUESTIONS & ANSWERS
APC GROUPER AND SYSTEM UPDATES

- **Which grouper was used for the data analysis?**
  - The 2014 3M APC Medicare grouper was used. In addition, results from the 2013 grouper were evaluated to help inform and improve the data analysis.
- **Why wasn't the current grouper version used in the data analysis?**
  - The 2014 grouper was used in order to match to the claims data time period. Using a grouper version that does not match the time frame of the data set could potentially increase the error rate because a more recent grouper version reflects coding guidelines not available when the 2014 claims were billed.
- **What analysis has been performed to understand the changes from the base period of 2014?**
  - No specific analysis has been performed, and billing practices and groupers need to change in tandem. However, the conversion factor based on the 2014 data set remains relevant as Medicare's updates are intended to be revenue neutral.
- **Will DSS stay current with Medicare and update the system every January and also implement any quarterly coding changes?**
  - Yes, DSS plans to stay current with Medicare and update the system with the January updates and also implement quarterly coding changes. The APC System Updates Issue paper will be revised to reflect this.

QUESTIONS & ANSWERS
DATA ANALYSIS

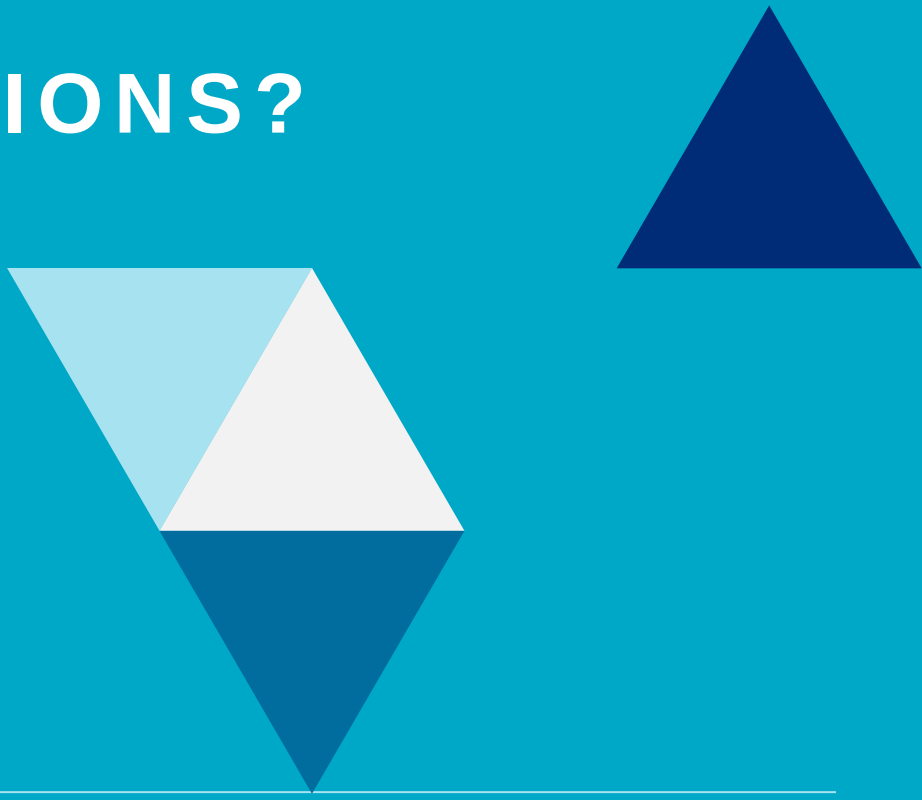
- **Will DSS provide a fiscal impact analysis by RCC or other category of service?**
  - An analysis by RCC was not planned because of the shift away from payment based on RCCs to payment based on procedure codes. The fiscal impact model considers all APC Payable services in aggregate.

QUESTIONS & ANSWERS
OTHER TOPICS

Questions related to the following topics are addressed in the provider training offered by HPE and/or provider notifications:

- Observations
- Professional billing guidelines
- Payment methodologies, including Enhanced Care Clinics
- Claim submission and billing changes

ADDITIONAL QUESTIONS?



NEXT STEPS & RESOURCES

NEXT STEPS

- Provider training.
- Finalize project documentation:
  - Distribute latest version of CT Addendum B
  - Distribute revised fiscal impact model.
  - Revise and publish FAQ.
- Implementation.

NEXT STEPS & RESOURCES
RESOURCES — ISSUE PAPERS

- The recommendations in the following issue papers will be adopted by DSS:
  - APC Policy Changes
  - APC System Updates
  - Basis for Fiscal Modeling
  - BH Services
  - Connecticut Addendum B
  - Edits and Billing Issues
  - OP Outliers
  - PCMH
  - Policy Exclusions
  - Professional Services

RESOURCES — WEBSITES

Connecticut Department of Social Services Reimbursement Modernization:

http://www.ct.gov/dss/cwp/view.asp?a=4598&q=538256

Connecticut Medical Assistance Program:

www.ctdssmap.com

MERCER

MAKE TOMORROW, TODAY