MAPOC

February 10, 2023

CT Department of Social Services

Agenda

HUSKY Finance – Part 2

Healthcare Coverage for Immigrants

Fertility coverage

Physician Fee Schedule

HUSKY Financing (Part 2)

Healthcare Coverage for Immigrants

Fertility Coverage in Medicaid

Fertility Coverage

Overview

As specified by CT Medicaid regulations, including the Physician and Outpatient hospital payment regulations, CMAP does *not* cover infertility treatment services.

For this purpose, treatment for infertility including, but not limited to, reversal sterilization, in-vitro fertilization, artificial insemination, cryopreservation, and fertility drugs, are not covered.

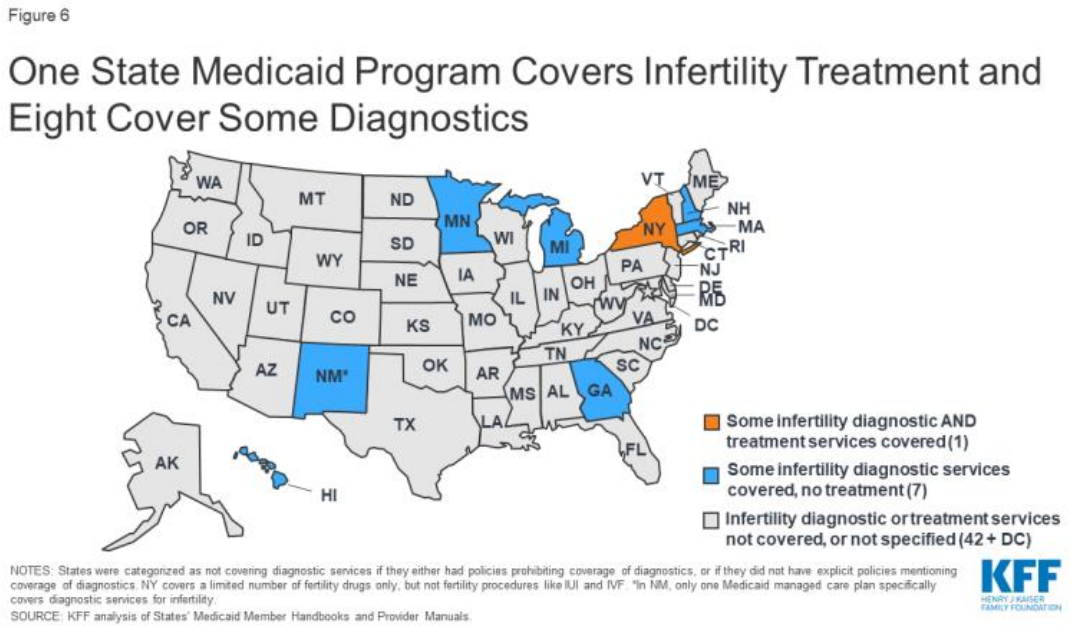
CMAP *does* provide coverage for family planning services including those that diagnose, treat, and counsel individuals of child-bearing age. Covered family planning services include, but not limited to reproductive health exams and lab tests to detect the presence of conditions affecting reproductive health.

CT Medicaid Payment Regulations:
Physician Sec. 17b-262-342. Goods and services not covered

The department shall not pay for the following goods or services or goods or services related to the following: (…) (8) infertility treatment

OP Hospital Regulation Sec. 17b-262-973.
Services Not Covered The department shall not pay for the following: 1. Any service identified on Addendum B as not covered or not reimbursable; 2. Any service to treat obesity other than those described in section 17b-262-970 (c)(9) of the Regulations of Connecticut State Agencies; 3. Infertility treatment or reversal of sterilization procedure

Other States



KFF. Coverage and Use of Fertility Services in the U.S. 2020 Report is here;

Physician Fee Schedule

Context for this section

Context

Several members of MAPOC requested that DSS present on how the physician fee schedule works in HUSKY

Our approach

Today, we are simply giving a "readout" of baseline policy and data

We are not endorsing any position or advocating any policy

HUSKY pays most* providers in one of four main ways

	(1). Provider fee schedule (most common)	(2). Cost-based (generally for institutions)	(3). Value based payments (small but growing)	(4). Grant based retrospective CPE claiming
Description	*Focus of today's presentation* HUSKY publishes a list of payments for each service and pays all providers who bill from that fee schedule accordingly	Creates provider-specific reimbursement based on a provider's costs	Pay providers based on the value (clinical and financial) they deliver to members	Waivers operated by other agencies where costs of services are funded through grant-based payments to providers and converted to rates for federal Medicaid claiming purposes
Example provider types	. Physicians, including specialists (e.g., cardiologists), clinics, PT, OT, SLP services, etc.	Nursing homes	Maternity providers, starting 2023	DDS waiver providers
Advantages	. Follows Medicare . Simple . Creates incentives for providers to be financially efficient	. Matches reimbursement to costs, reducing costs . Avoids potential incentives to "cream or skim" healthier patients	. Gives providers incentives to improve quality and lower costs . Can encourage holistic treatment of disease	• Grant-based funding supports greater flexibility for providers • Agency / provider share responsibility for meeting federal claiming requirements.
Main disadvantages	. Little financial incentive to keep patients healthy . Could "overpay" some providers, paying more than costs	. Dulls incentives for providers to operate efficiently . Traditionally not linked to patient acuity	. Could potentially result in "stinting" or "cream skimming" if appropriate policies to mitigate are not in place	Delay in finalization and truing up expenditures for claiming purposes.

* There are some important provider types who are <u>not</u> paid according to these three buckets. For example, Federally Qualified Health Centers (FQHCs) are paid via the federally mandated prospective payment system (PPS). HUSKY pays our hospitals via an APR DRG system for inpatient services and an OPPS APC methodology for outpatient services.

Provider fee schedules: definition and examples

Definition

Document that specifies the rate that will be paid to a group of providers enrolled under a specific provider category for a specific service.

For example – The CT Medicaid Physician Surgical fee schedule will provide the specific rate that will be reimbursed to an enrolled gastroenterologist for a colonoscopy

Some examples of where, in HUSKY, we use a fee schedule

Physicians (including APRNs, PAs, CNMs, Podiatrists, Optometrists)	Freestanding Clinics (Behavioral Health, Medical, Rehab, ASC, Dialysis)	Medical Equipment, Devices and Supplies	Behavioral Health Clinician / Psychologists
Radiology	Home Health	Violence Prevention Professional	Autism Spectrum Disorder Services
Independent Therapy	Acupuncture	Birth to Three	Chiropractor
Lab Services	Naturopath	Vision Services	Dental Services

How Medicare sets its fee schedule – the RUC & RVUs

History

RVU's (Relative Value Units) and the RUC (RVU Updated Committee) implemented by Medicare in 1991 and 1992 through the Omnibus Budget Reconciliation Act of 1989

Created in response to providers billing "usual, customary, and reasonable" rates that allowed providers to set their own rates within certain parameters and was thought to be leading to increasing price inflation and marked price variability.

References:

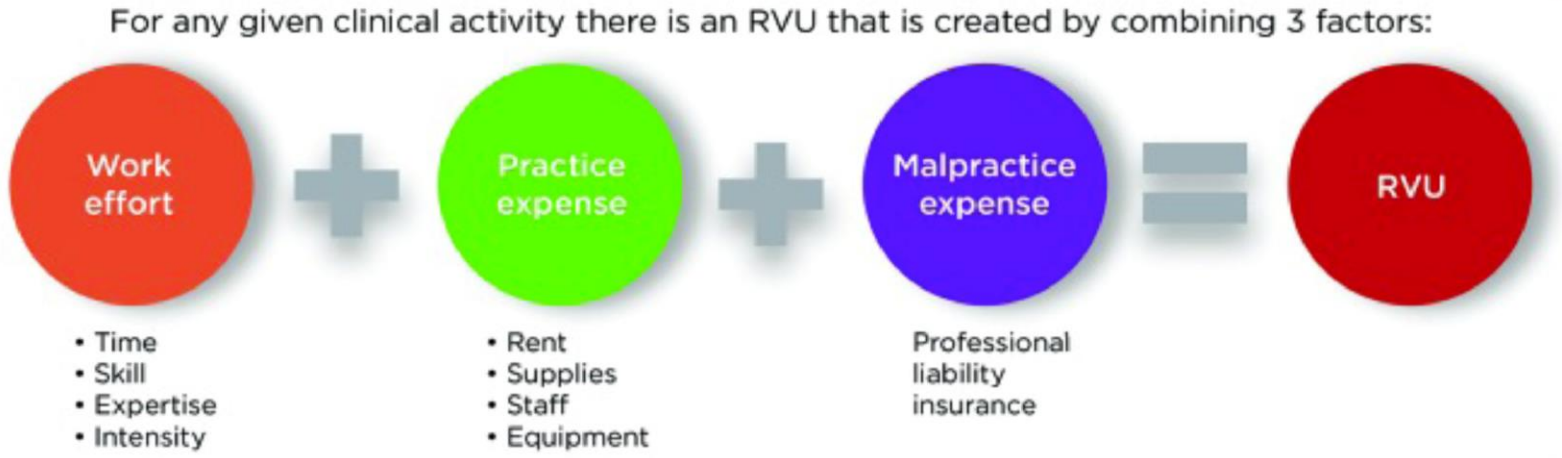
- https://economics.harvard.edu/files/economics/files/ms28996.pdf
- Clemens J, Gottlieb JD. In the shadow of a giant: Medicare's influence on private physician payments. Journal of Political Economy. 2017 Feb 1;125(1):1-39.
- Calafell J, Cohen JL. What the heck are RVUs? A guide to productivity based compensation. InSeminars in Colon and Rectal Surgery 2020 Mar 1 (Vol. 31, No. 1, p. 100711). WB Saunders.

How RVUs are set

RUC = group of 32 mostly specialist providers convened by the AMA (American Medical Association); charged with recommending updates to the rates set by Medicare

RUC evaluates proposals from medical societies to determine the relative resource costs of services and update the RVU for specific services.

Committee's recommendations influence not only Medicare's direct expenditures, but also indirectly shape pricing in the overall market for physician services, valued at $480 billion per year or 2.7% of the US GDP in 2017



Fee schedules: history and current rates

History

In 2008, pursuant to PA 07-185, rates reimbursed on the physician and clinic fee schedules were increased

The 2007 Medicare fee schedule was chosen as the basis for the rate increases. Reimbursement was set at a % of the 2007 Medicare fee schedule for each provider category.

Absent federal or state mandate to update provider rates, overall fee schedules updates must be approved as part of the overall biennium budget process. (e.g., Increased Payments for Primary Care Services initially mandated via Sec. 1202 of the ACA)

Note: The Governor's budget includes $1,000,000 for a comprehensive HUSKY provider rate study

Current fee schedule (not exhaustive)

Provider fee schedule	How we set the fee schedule
Physician	. Non-Primary Care ~ 57.5% of 2007 Medicare . Primary Care ~95% of calculated 2014 Medicare . OB services ~145% & 110% for high-risk radiology of 2007 Medicare
Medical Clinics	~ 80% of 2007 Medicare
Radiology	~ 57.5% of 2007 Medicare Screening mammography increased ~4.7-43.6% in 2022
Rehabilitation Clinics	~ 95% of 2008 or 2013 Medicare
Dialysis Clinics	~ 100% of the 2007 Medicare
Ambulatory Surgery Centers	~100% of 2007 Medicare however, in 2008 Medicare transitioned to an OPPS reimbursement structure
Medical Equipment, Devices and Supplies (MEDS)	~ 85% of the 2007 Medicare April 2018: Cures Act DME Demonstration codes were priced ~100% Medicare
Family Planning Clinics	Office Visits ~90% of the Medicaid OB rate Surgical ~ 57.5% 2007 Medicare