MAPOC Meeting

March 2024

CT Department of Social Services

Agenda

- Rate Study Phase 1 Readout
- Fraud, Waste, and Abuse
- Family planning services

Rate Study Phase 1 Readout

Context

As a "managed fee-for-service" Medicaid program, Connecticut directly sets reimbursement rates and methodology for its providers

Pursuant to Public Act No. 23-186, DSS commissioned a two-part study to examine Medicaid reimbursement

- Phase One (completed): studied behavioral health services, dental services, and physician and other professional service providers. These services represented spending of $760.2 million in SFY 23, or 18.2% of entire Medicaid spending
- The study authors analyzed the ~11k codes in this portion of the program to other payers: Medicare and other Medicaid programs
- The study authors recommended a series of process recommendations to promote a more rational rate setting process

Rate Study: Definition and purposes

- What a rate study *is*: a data-driven review of rate parity for Medicaid when compared to peer payers and identification of rates with the largest difference when compared to the benchmark
- What a rate study is *not*: enactment of any changes to the programs
- Rate study alone does not make specific recommendations with respect to dollar amounts for any rate adjustments
- Rather, it makes general recommendations regarding actions an agency or state should consider

Overall approach: Benchmark rates to Medicare when possible; when not possible, benchmark to selected Medicaid

- In Phase 1, nine service categories were analyzed: Behavioral Health, Physician-Surgery Facility, Autism Services, Physician-Surgery, Physician/Outpatient-Facility, Physician/Outpatient, Physician-Anesthesia, Physician-Radiology, Dental

- **Medicare**. When possible, we benchmarked our rates to Medicare. Medicare has a comprehensive, widely used, method for setting and updating provider rates. There is no specific federal guidance from CMS regarding how states should benchmark their rates or to what percentage. States have discretion in the development of their own reimbursement methodologies, as long as access is adequate, and can select a benchmark percentage within available state appropriations. The rate study uses 80 percent of Medicare benchmark for illustrative purposes and as a basis for comparison

- **Medicaid**. Medicaid covers a broader range of services than Medicare. For services without a Medicare equivalent, we compared Connecticut rates to the average rate set by the Five State Comparison: Maine, Massachusetts, New Jersey, New York, and Oregon. The states selected for the Five State Comparison were of interest due to varying factors: similar economic indices and geographic location, states neighboring CT, 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)

MAJOR FINDINGS

1 Coverage

Contractor successfully "matched" the vast majority of Phase 1 spending to benchmark rates

In Phase 1, we analyzed $760.2 million in spending

We examined other payers (Medicare, Medicaid) to see how much those payers paid for the same services.

The vast majority (92%) of the $760.2 million analyzed in Phase 1 had an equivalent from another payer. Only 8% of the Phase 1 spending did not have a comparable code with the other payers

2 Lots of variation *within* service category

Within each of the 9 service categories, large variation in how CT rates compare to benchmark

Consider, for example, the largest service category Physician/Outpatient. Here, for non-facility codes, the average comparison to Medicare was 65.3%. There is large variation around this average, however

Lower. Almost a third (31.2%) of rates were less than 50% of Medicare (with 6.3% less than 25% of Medicare)

Higher: A fifth (20.3%) of rates were more than 75% of Medicare (with 7.3% more than 100% of Medicare)

3 Lots of variation *across* service category

Across 9 service categories, large variation in how CT rates compare to benchmark

Behavioral health was 44.2% of benchmark payment

Dental was 100.3% of benchmark

The other 7 categories ranged from 71.1% to 97.2% of benchmark

4 Largest differences

Relative to benchmark, behavioral health was by far the lowest

Behavioral health was the clear outlier: it had the lowest percent of benchmark

Study Authors' recommendations

Rate Study had multiple finds with recommendations; below are four

Recommendation	Detail
Adjust rates for behavioral health using a portion of available resources in enacted budget	Begin review of behavioral health services and stakeholder process to best target a portion of the $7m state share in the enacted budget. Then, within available appropriations, develop a new rate methodology that examines current codes and service definitions and modify those as necessary to better reflect how services are delivered. New rate model would be based on independently determined cost information and market factors such as BLS, wage information, and provider qualifications.
Adjust physician specialist services rates to a specified Medicare benchmark percentage	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 would be reviewed for recommended adjustments in accordance with available appropriations. The rate review would also identify codes that are 'delinked' from Medicare and all rates would be brought under the same benchmarking policy.
Standardize rates for autism spectrum disorder (ASD) services	Resolve inconsistencies in reporting and defining services across ASD services. Use 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. Adjust direct service treatment rates to the Five-State Comparison Rate.
Adjust dental fees using a specified percentage of the Five-State Benchmark	Review fee schedule for dental services. Within the dental fee schedules, there is a large variation in comparison values across services. 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.

Recommended Next Steps

(1). Gather stakeholder feedback on recommendations in next 6 weeks

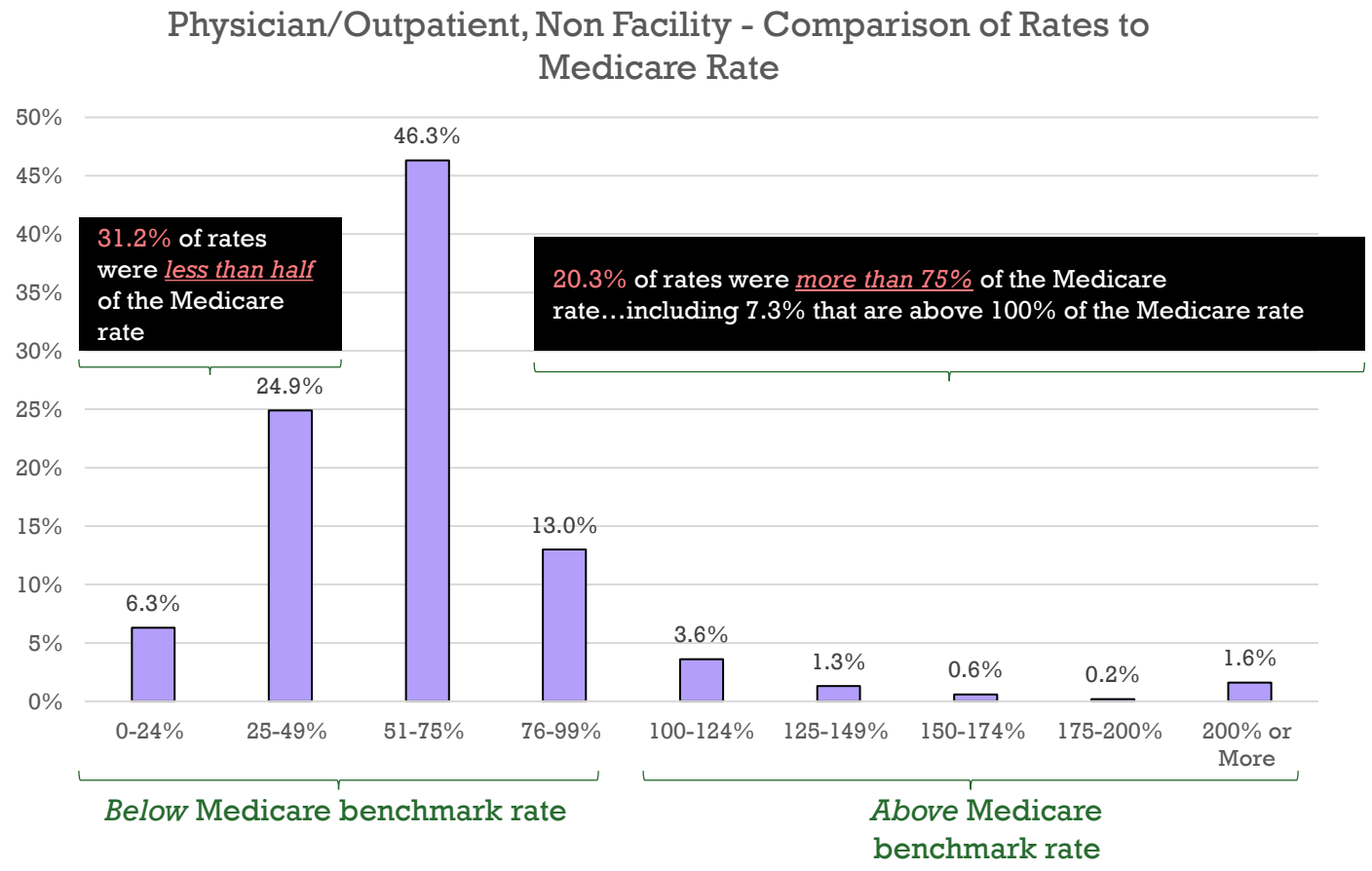
(2). Make recommendations regarding rate adjustments within available resources appropriated in the enacted budget ($7 million state share)

APPENDIX

[Finding #2]: Lots of variation *within* service category

Within each of the 9 service categories, large variation in how CT rates compare to benchmark

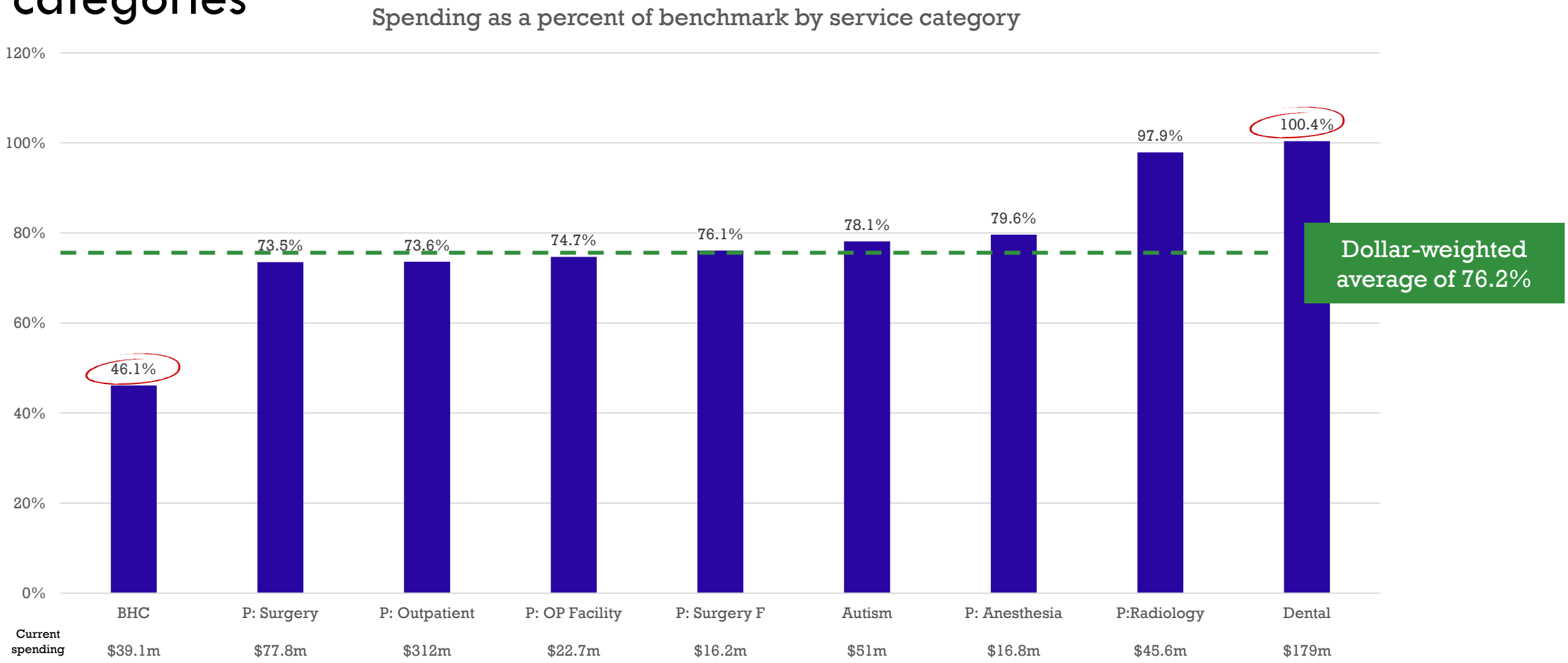
Example: Consider Physician/Outpatient (the largest service category). Here, for non-facility codes, the average comparison to Medicare was 65.3%...but there is large amount of variation around that average



Note: 2.2% are unmatched and not shown here

[Finding #3]: Lots of variation *across* service categories

Across 9 service categories, large variation in how CT rates compare to benchmark

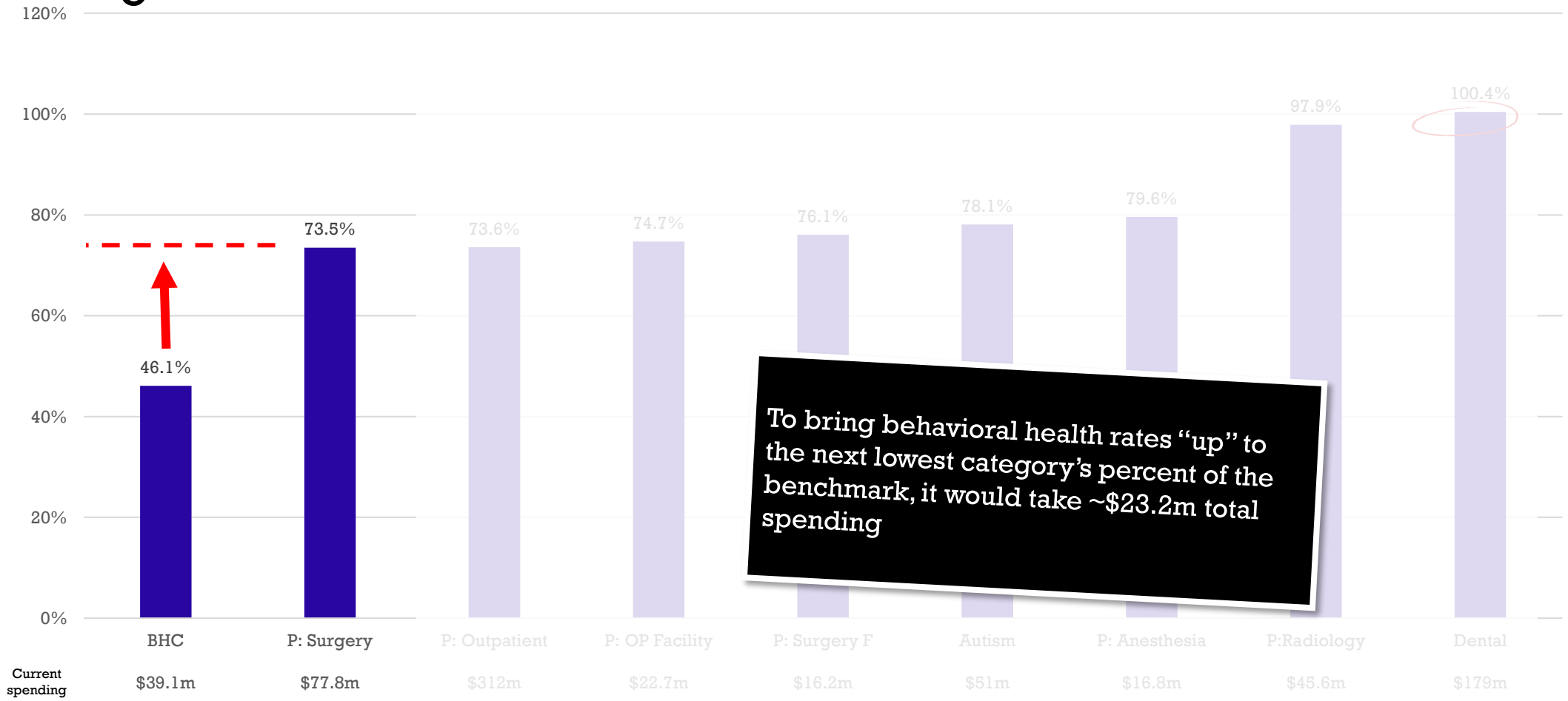


Notes: BHC is "Behavioral Health Clinic". "P:" means "Physician". "F" means facility

[Finding #3]: Lots of variation *across* service categories

Across 9 service categories, large variation in how CT rates compare to benchmark

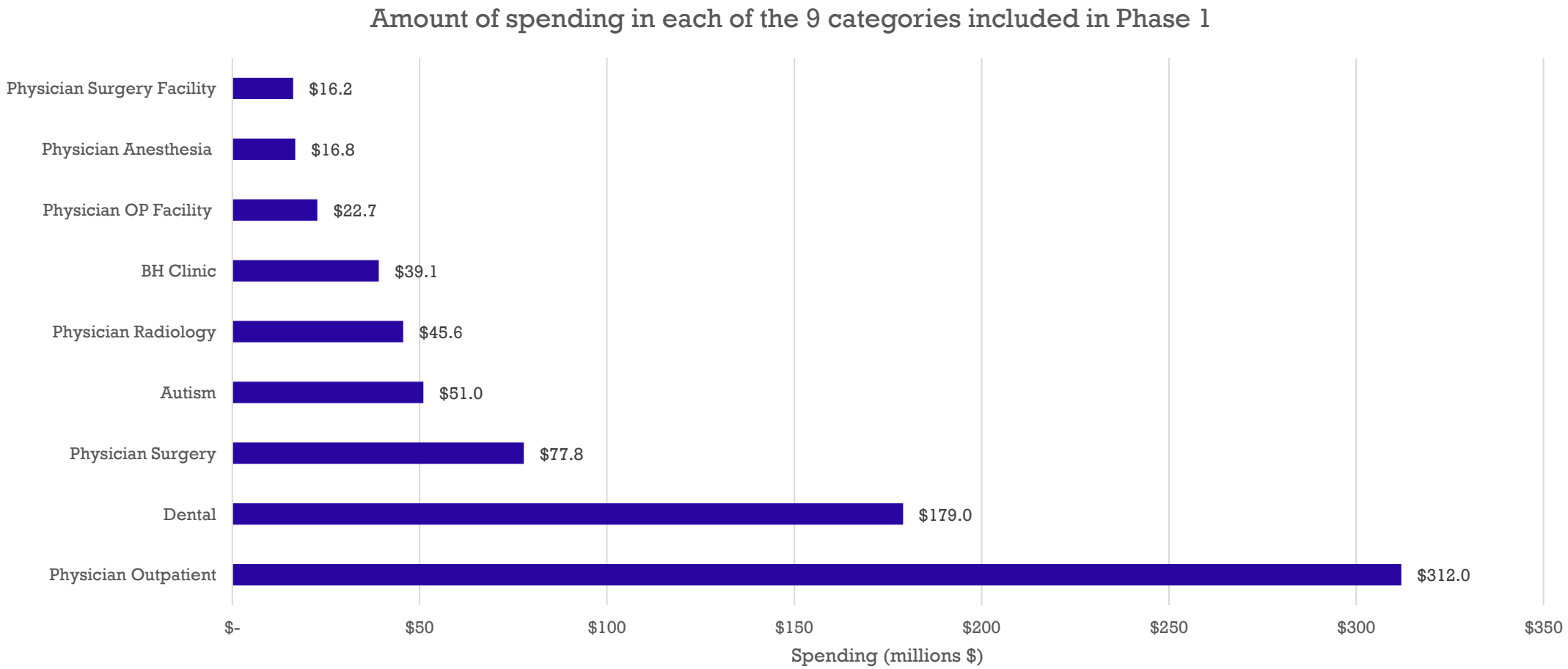
Spending as a percent of benchmark by service category



To bring behavioral health rates "up" to the next lowest category's percent of the benchmark, it would take ~$23.2m total spending

Notes: BHC is "Behavioral Health Clinic". "P:" means "Physician". "F" means facility

[Backup]: We divided Phase 1 spending into 9 categories, which collectively comprise ~18% of total Medicaid spending



Fraud, Waste and Abuse

Fraud, Waste and Abuse (FWA) and the DSS Office of Quality Assurance Overview

What is Fraud, Waste and Abuse (FWA) - Medicaid

- **Fraud**: someone intentionally lies or misrepresents the facts within the Medicaid program.
- **Waste**: someone overuses or overprovides health services carelessly.
- **Abuse**: medical providers do not follow standard practices, leading to expenses and treatments that are not needed or services that are not delivered.

Examples of FWA

Provider Level

- Billing for services not rendered.
- Providing services which are not medically necessary.
- Billing for a more costly service than what was performed.
- Altering / Falsifying records.

Client Level

- Not reporting employment wages or other recurring income.
- Not reporting the presence of household members / including household members not present.
- Applying for assistance in more than one state at a time.

Scope of the FWA Problem Nationally

- The National Health Care Anti-Fraud Association conservatively estimates that more than $100 billion a year is lost to Medicare and Medicaid fraud. *
- Medicare spends about $900 billion a year and Medicaid spends approximately $735 billion a year on its beneficiaries (2021). **
- Even these conservative numbers show that $1 out of every $16 spent in the Medicare and Medicaid programs is fraudulent.

*How Medicare and Medicaid fraud became a $100B problem for the U.S. (cnbc.com)

**NHE Fact Sheet | CMS

Scope of the FWA Problem - Connecticut

- Using round numbers, with Medicaid expenditures of approximately $8 billion * on an annual basis, about $500 million is lost to fraudulent activities each year.
- With roughly 3.6 million ** residents in CT (2021), it could cost the average family of four $550 per year.
- This does not include items that are not fraudulent, such as legitimate billing errors. (QA provider audits during SFY 2023 uncovered $5.5m in overpayments out of a universe of approximately $227m. This equates to about 2.5%)

*Annual Medicaid & CHIP Expenditures | Medicaid

**U.S. Census Bureau QuickFacts: Connecticut

DSS Office of Quality Assurance

The Office of Quality Assurance (OQA) is responsible for ensuring the fiscal and programmatic integrity of programs administered by the Department of Social Services.

With the enormous spend on the Medicaid program, many of the OQA resources are utilized reviewing the Medicaid program.

Quality Assurance Units

We are made up of eight distinct units:

1. Audit Division
2. Special Investigations Division (Provider Fraud)
3. Provider Enrollment Unit
4. Client Investigations
5. Resources and Recoveries
6. Quality Control
7. Claims / Overpayment Processing Unit
8. Third Party Liability Team (TPL)

(1). Audit Division

- Performs audits of medical and health care providers that are paid through the medical assistance programs administered by the Department.
- Identifies overpayments through focused integrity reviews.
- Provides support and assistance to the Department's Special Investigations Division.
- Coordinates the Department's responses to outside audit organizations' reviews performed on the Department, including, but not limited to, the State Auditors of Public Accounts and federal audit organizations.

(2). Special Investigations Division

- Coordinates and conducts investigative activities related to allegations of provider fraud in the Connecticut Medical Assistance Program.
- When appropriate, credible allegations of fraud are referred to the Department's law enforcement partners pursuant to a memorandum of understanding (MOU). Parties to the MOU are the Office of the Chief State's Attorney, the Office of the Attorney General and the U.S. Department of Health and Human Services' Office of Investigations. Each entity is responsible for independently investigating the Department's referral to determine if a criminal and/or civil action is appropriate.
- Substantiates whether complaints received from various sources are valid and determines the proper disposition of the complaint.

(3). Provider Enrollment Unit

- The Provider Enrollment Unit is responsible for the review and approval of all provider enrollment and re-enrollment applications, on an ongoing basis. Coordination of efforts between the Provider Investigations Unit and Provider Enrollment Unit strengthens Connecticut's program integrity efforts.

(4). Client Investigations and Resources/Recoveries

- The **Client Investigations Unit** investigates alleged client fraud in various programs administered by the Department. This unit performs investigations via pre-eligibility, post-eligibility and other fraud investigation measures that include, but are not limited to, data integrity matches with other state and federal agencies. This unit also oversees the toll-free Fraud Hotline 1-800-842-2155 that is available to the public to report situations where it is perceived that a public assistance recipient, or a medical provider may be defrauding the state.
- The **Resources and Recoveries Unit** is charged with ensuring that the Department is the payer of last resort for the cost of a client's care by detecting, verifying, and utilizing third-party resources; establishing monetary recoveries realized from property sales; and establishing recoveries for miscellaneous overpayments.

(5). Quality Control Unit and Claims Overpayment Unit

- The **Quality Control Division** is responsible for the federally-mandated reviews of Medicaid and the Supplemental Nutrition Assistance Programs (SNAP). A newly-established set of federally-required Medicaid reviews has been implemented under the Payment Error Rate Measurement program. Reviews of other CMAP programs and special projects may also be performed by this unit.
- The **Claims Overpayment Unit** is charged with processing overpayments resulting from changes in a client's eligibility, as well as the collection of already established claims. The claims are specific to SNAP, the Temporary Assistance for Needy Families program, and state-administered cash assistance programs.

(6). Third Party Liability Team

- The **Third-Party Liability Division** is responsible for the Department's compliance with federal Third Party Liability requirements and recovering tax-payer funded health care from commercial health insurance companies, Medicare and other legally liable third parties. The Division manages programs that identify client third party coverage and recover client health care costs.

(7). Provider / Client Abrasion

- Providers view audits negatively because of what is perceived as a high volume of medical record requests, administrative costs, and any fiscal penalties that are levied upon them from the results of audits or reviews.
- Providers feel that they are not always told what the auditors are looking for and feel that their overall experience is abrasive.
- For audits, providers view the extrapolation process as unfair. The extrapolation process, however, is defined in state statute and is a very common methodology when only testing a subset of a population.

(8). Provider / Client Abrasion Continued

- For provider investigations, the process can be very long, and the Department can not release information because it may jeopardize law enforcement agency investigations. Provider relations can become more abrasive when the Department implements a payment suspension on the provider.
- For provider enrollment, the Department does, at times, deny provider applications or disenrollment providers from the program on a case-by-case basis.

How to Alert the Department

- Toll-free Fraud Hotline **1-800-842-2155** that is available to the public to report situations where it is perceived that a public assistance recipient, a provider, or a medical provider may be defrauding the state.
- Link on the QA webpage to report suspected Fraud and Abuse of DSS programs. On the Department of Social Services webpage there is "Report Fraud" link as well. It brings you to a "Client Complaint Form" and a Provider/Vendor Complaint Form" along with descriptions of examples of fraudulent activities.

Family planning services

Family Planning Services

- Mandatory Medicaid coverage
  - Per section 1905(a)(4)(C) of the Social Security Act: "family planning services and supplies furnished (directly or under arrangements with others) to individuals of child-bearing age (including minors who can be considered to be sexually active) who are eligible under the State plan and who desire such services and supplies"
  - States are given discretion in identifying the specific services and supplies covered
- Family planning services include services relating to the individual's desire to prevent pregnancy, or regulate the number and spacing of children
- Most services billed that can be identified as family planning are eligible for 90% federal match

Family Planning Service Coverage

- Services covered include:
  - Reproductive health exams (including family planning patient counseling & education)
  - Screening, testing, treatment, and pre- and post-test counseling for sexually transmitted diseases & HIV
  - Lab tests to detect the presence of conditions affecting reproductive health
  - Food and Drug Administration (FDA) approved contraceptives& birth control options (including, but not limited to, hormonal contraceptive pills, patches, long-acting reversible contraceptive devices, condoms & spermicide)
  - Sterilizations (i.e., tubal ligation, vasectomies) *must comply with 42 CFR 441.257 and 42 CFR 441.258*

- Services not covered:
  - **Fertility** treatment services are currently excluded from coverage per Regulations of Connecticut State Agencies
    - (e.g., in vitro fertilization (IVF), intrauterine insemination (IUI), cryopreservation, reversal of sterilization procedures)

Note: Current federal Medicaid interpretation of the family planning services benefit category includes the coverage of fertility treatments and, as a result, categorizes these services (the fertility services only) as eligible for 90% federal match. It should be noted however that, barring a federal update to existing statutory language to codify the explicit inclusion of fertility treatment services as family planning, federal interpretation could be amended under future CMS administrations, thereby changing the federal match to the standard Medicaid match, which is generally 50%.

Fertility Services: Other State Medicaid Coverage (KFF)

Diagnostic Services:

- Some states specifically cover infertility diagnostic services
  - GA, HI, MA, MI, MN, NH, NM and NY all offer at least one Medicaid plan with this benefit, but the range of diagnostics covered varies
  - NY specifically covers office visits, HSGs, pelvic ultrasounds and blood tests for infertility
  - GA includes lab testing for infertility assessment, but not imaging or procedural diagnostics

Fertility Treatment Services:

NY characterizes infertility by the incapacity to conceive, defined by the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse for individuals 21 through 34 years of age, or after six months for individuals 35 through 44 years of age

Coverage includes medically necessary ovulation enhancing drugs and medical services related to prescribing and monitoring the use of such drugs for individuals 21 through 44 years of age.

Limited to coverage for three (3) cycles of treatment per lifetime

*Other states specifically do not cover infertility diagnostics, or more generally do not cover "infertility services," which likely includes diagnostics. Others do not mention infertility diagnostics in their Medicaid policies, meaning the beneficiary would need to check with their Medicaid program to see if these services are covered