Medicaid Rate Study: Phase 1

Executive Summary

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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

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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

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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)

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MAJOR FINDINGS

1 Coverage	2 Lots of variation *within* service category	3 Lots of variation *across* service category	4 Largest differences
Contractor successfully "matched" the vast majority of Phase 1 spending to benchmark rates	*Within* each of the 9 service categories, large variation in how CT rates compare to benchmark	*Across* 9 service categories, large variation in how CT rates compare to benchmark	Relative to benchmark, behavioral health was by far the lowest
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	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)	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	Behavioral health was the clear outlier: it had the lowest percent of benchmark

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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.

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Recommended Next Steps

(1). Gather stakeholder feedback on recommendations within 6 weeks from the date of the Joint Human Services-Appropriations Committees Hearing

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

Physician Specialist Rate Adjustment Considerations

Context for Physician Specialist Services Recommendations

- Physician services include physician office and outpatient services (inclusive of office visits, medical services), surgical services, anesthesia, and radiology
- CT Medicaid non-facility rates for physician surgery services average 56% of the Medicare non-facility rates
- CT Medicaid non-facility rates for physician office & outpatient services average 89.2% of the Five-State Comparison Rate and 65.3% of the Medicare non-facility rates **

  **(*inclusive of primary care and specialists; includes enhanced reimbursements for obstetrics and pediatric services*)
- Out of a total of $7 million appropriated to DSS for the rate study, DSS is recommending $2 million for physician specialists, with the balance to be allocated to behavioral health services

Connecticut Department of Social Services
Making a Difference

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

Spending as a percent of benchmark by service category

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

New Funding Considerations

1. Where do we have access issues

2. Where would an investment improve/increase access and decrease downstream costs

3. Where do we have the greatest disparity in the rates

Draft Recommendation: Physician Specialist Services

Straw Model:
Reflects Draft Recommendations to Elicit Stakeholder Feedback before Presenting to Sister Agencies, Commissioner & OPM for a Final Recommendation

Potential Funding for Physician Specialist Services - $2M

- Increase non-facility rates for evaluation and management (E/M) services when billed by specialists
  - CPT codes in the 99202 – 99493 range that are currently payable under CMAP
  - Rate increase ~4.5%
- Specialist defined as physicians, advanced practice registered nurses, physician assistants, in addition to services billed by optometrists and podiatrists in the specific specialty designations
  - Specialties for whom the E/M rate is higher than the default physician specialist rate are excluded *(pediatric, neonatal, and obstetrics are reimbursed a higher E/M due to the HUSKY Health Primary Care Rates and the enhanced obstetric rate)*

Proposed Physician Specialist Eligible for E/M Rate Adjustment

Orthopedic Surgery	Physical Medicine and Rehabilitation	Neurological Surgery
Certified Registered Nurse Anesthetist (CRNA)	Pain Medicine	Oncology
Neonatal Nurse Practitioner	Medical Genetics	Plastic Surgery
Oral and Maxillofacial Surgeon	Sleep Medicine	Colon and Rectal Surgery
Hepatology	Transplant Surgery	Psychiatry
Allergy	Gastroenterology	Pulmonology
Anesthesiology	General Surgery	Radiology
Cardiology	Nephrology	Pathology
Cardiovascular Surgery	Thoracic Surgery	Rheumatology
Dermatology	Urology	Neonatal-Perinatal Medicine
Ophthalmology	Endocrinology	Neurology-Special Qualification in Child Neurology
Psychiatric/Mental Health Nurse Practitioner	Hematology	Neuromusculoskeletal & Sports Medicine
Otology, Laryngology and Rhinology	Infectious Diseases	

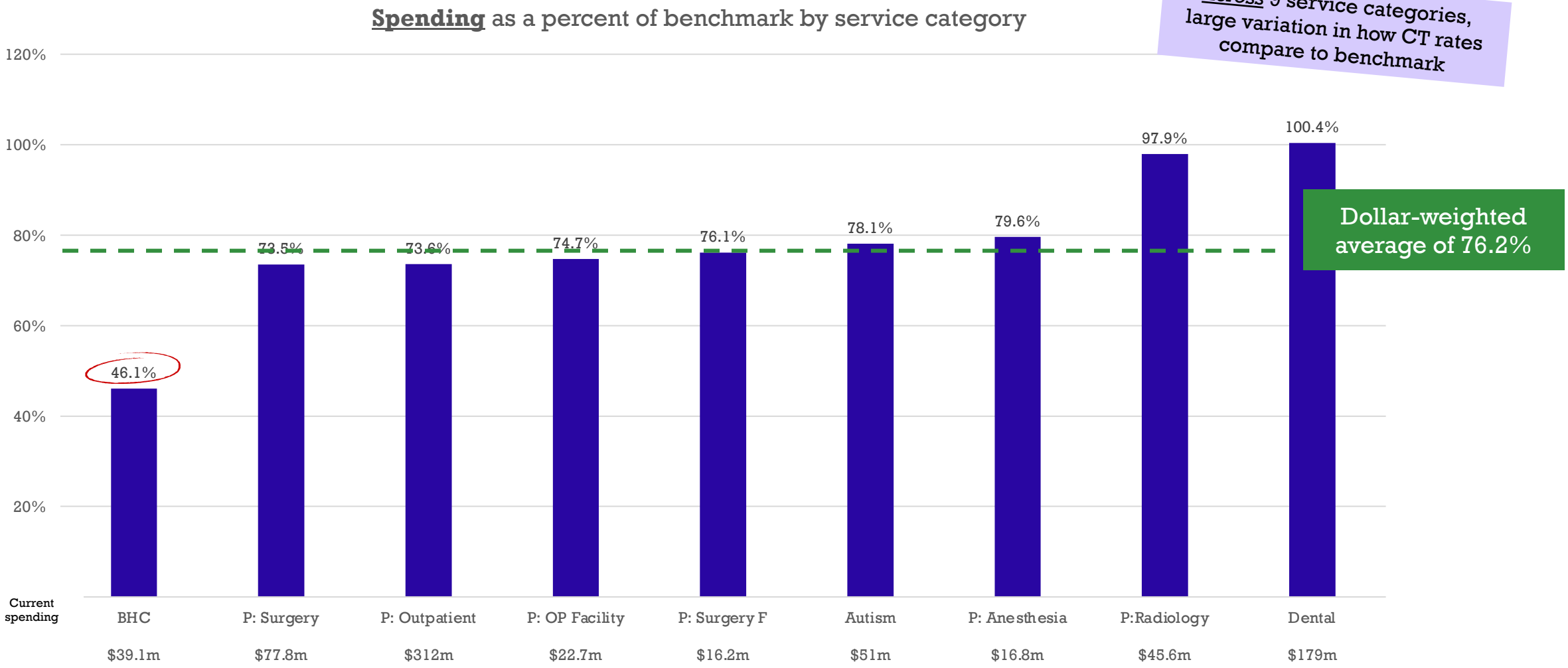
E/M Increase Examples

Procedure Code	Short Description	Current Rate	Adjusted Rate
99203	Office visit new low 30 min	$44.98	$47.00
99204	Office visit new low 45 min	$66.40	$69.38
99205	Office visit new low 60 min	$100.17	$104.67
99212	Office o/p est sf 10 min	$26.83	$28.04
99213	Office o/p est low 20 min	$42.93	$44.86
99214	Office o/p est mod 30 min	$64.99	$67.91
99243	Off/op cnsltj new/est low 30	$88.26	$92.23
99244	Off/op cnsltj new/est mod 40	$128.93	$134.73
99417	Prolng op e/m each 15 min	$57.16	$59.73
99442	Phone e/m phys/qhp 11-20 min	$42.93	$44.86

Evaluation and Management (E/M) Services Proposal Rationale

- **E/Ms serve as the primary access to care point for services**
  - Account for the time required to evaluate and manage a patient (~1/3 of specialty billing)
  - Usually performed prior to other procedures
  - Billed for new and established patients
  - Multiple E/Ms can be billed to account for the level of specialty care required by the patient
  - With limited funding, E/Ms are the best approach to target improvements to access to care
    - Reduces selection bias
  - Account for services across various settings
    - Office or other outpatient setting, hospital inpatient and observation care, consultations, emergency department
- **The E/M range best approach to increasing the probability for improved/increased access & decrease downstream costs**
  - Targeting E/Ms is recommended as the best way to improve access to care & potential downstream costs (incentivize enrollment, retain providers, encourage specialists to open panels)

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



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Some specialists do not bill E/Ms as often (i.e., anesthesiologists, radiology)

Submit comments related to Physician Specialist Adjustment Recommendation to:

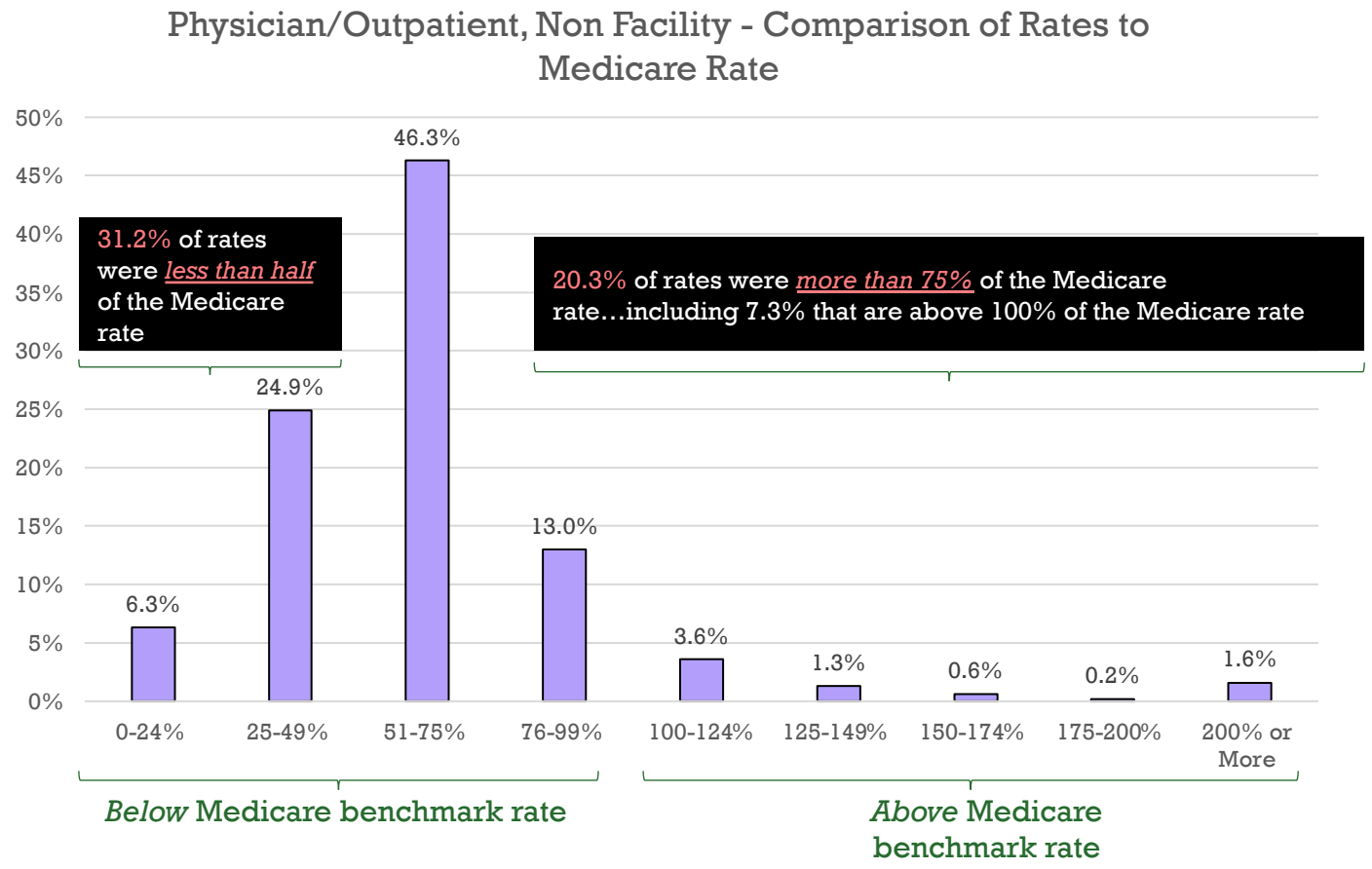
Nina Holmes @ nina.holmes@ct.gov

APPENDIX 1 – Study Findings

[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



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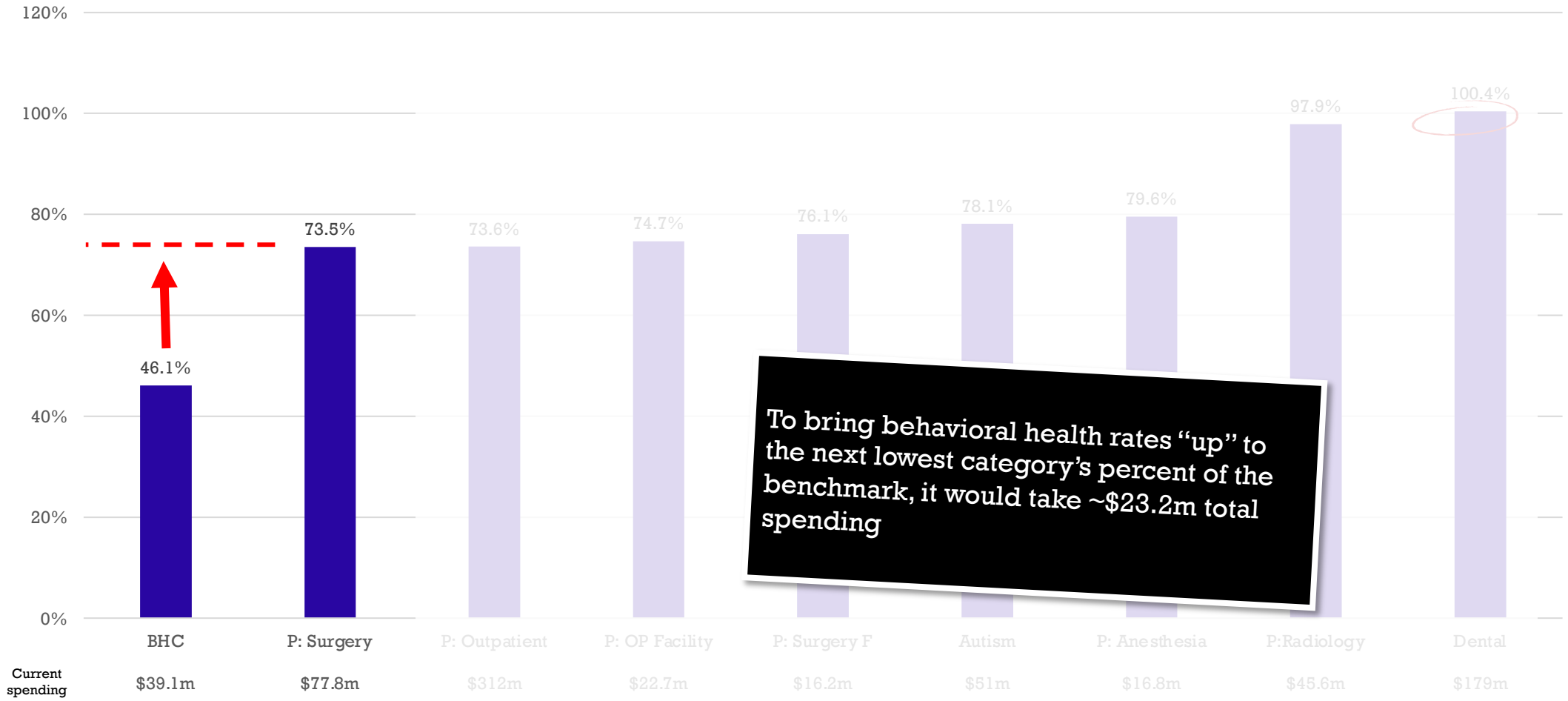
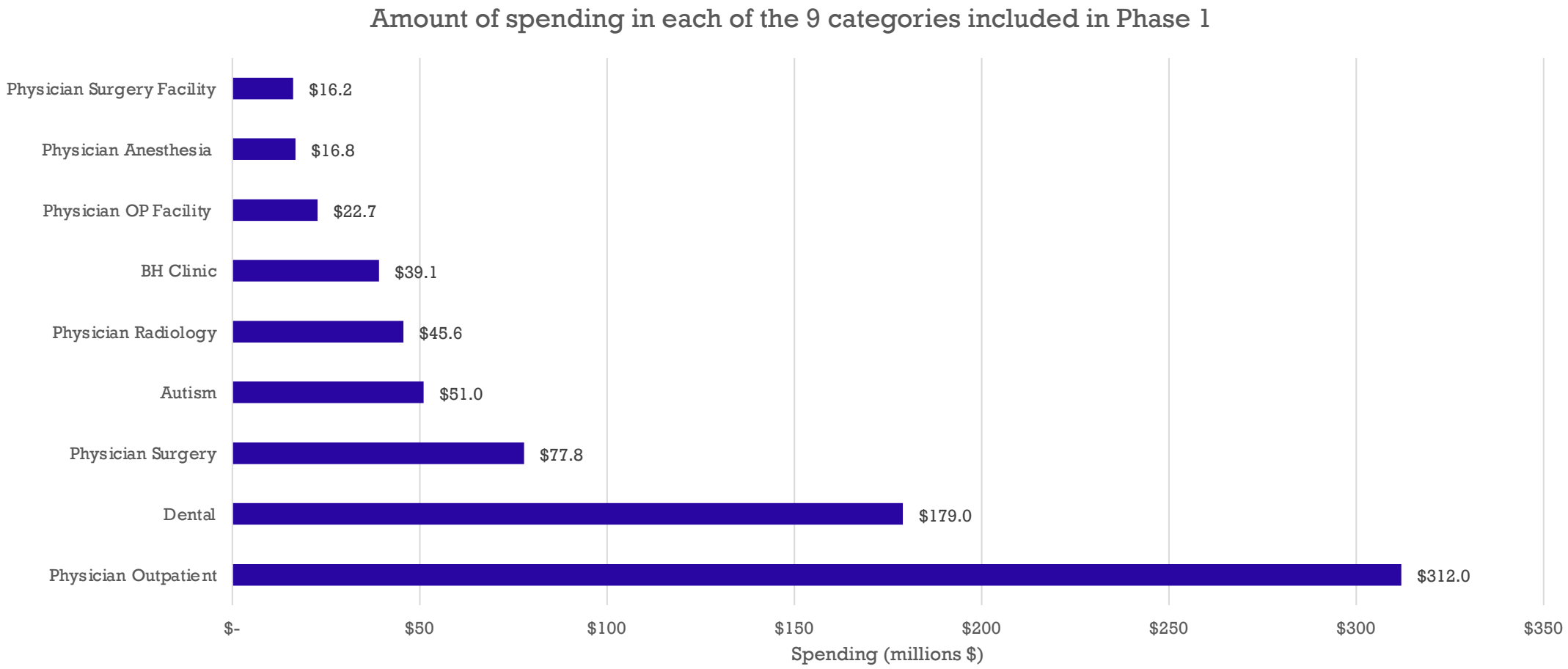


To bring behavioral health rates "up" to the next lowest category's percent of the benchmark, it would take ~$23.2m total spending

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



APPENDIX 2 – Behavioral Health Recommendation

Behavioral Health

Deep Dive

Context for Behavioral Health Recommendations

- Behavioral health, inclusive of licensed behavioral health practitioners and clinics, represented the greatest rate disparity when compared to five other Medicaid states
- The proposal includes licensed behavioral health practitioners and clinics
- Clinics: licensed behavioral health clinics licensed by DCF and/or DPH
- Twelve (12) procedure codes were used for the clinic analysis
- Out of a total of $7 million appropriated to DSS for the rate study, DSS is recommending $5 million for behavioral health

Twelve Procedure Codes Analyzed for Behavioral Health Clinics

			CT Claims Data					
Procedure Code	Modifier	Description	2023 "Max" Rate In place of Non-Facility	Units Paid	Allowed Amount	Average Payment per Unit	Average of All Other State Medicaid Rates	Connecticut as % of All Other State Medicaid Rates
H0014		Alcohol and/or drug services; ambulatory detoxification	$110.67	384	10,812	$28.16	$335.58	33.0%
H0015		Alcohol and/or drug services; intensive outpatient (treatment program that opera	$173.62	103,479	16,737,650	$161.75	$398.30	43.6%
H0035		Mental health partial hospitalization treatment less than 24 hours	$237.46	3,686	873,194	$236.89	$276.46	85.9%
H2012		Intensive outpatient psychiatric services per diem	$85.31	21,292	1,800,593	$84.57	$52.15	163.6%
H2019		Therapeutic behavioral services per 15 minutes	$22.49	453,345	14,747,006	$32.53	$24.98	90.0%
S9480		Intensive outpatient psychiatric services per diem	$147.73	33,153	4,799,944	$144.78	$190.16	77.7%
S9484		Crisis intervention mental health services per hour	$88.40	1,411	124,035	$87.91	$133.87	66.0%
S9484	HT	Crisis intervention mental health services per hour	$125.00	56	7,250	$129.46	$158.18	79.0%
S9485		Crisis intervention mental health services per diem	$182.00	3,714	675,948	$182.00	$1,083.30	16.8%
S9485	HT	Crisis intervention mental health services per diem	$225.00	427	113,240	$265.20	$1,053.64	21.4%
T1016		Case management each 15 minutes	$15.60	25,246	393,744	$15.60	$27.44	56.9%
T1017		Targeted case management each 15 minutes	$22.49	88,594	2,720,754	$30.71	$169.50	13.3%

New Funding Considerations

1. Where do we have the greatest disparity in the rates
2. Where do we have access issues
3. Where would an investment improve/increase access and decrease downstream costs
4. Reimbursement rates and the service system for substance use disorder (SUD) treatment services will be reviewed and potentially modified throughout the term of the SUD demonstration waiver should there be additional revenue from the waiver (e.g., SUD IOP)

Stakeholder Engagement Plan

- By March 5th: State agency review and approval of recommendations in principle

- By March 13th: Three provider stakeholder meetings:
  - March 6th: The Alliance
  - March 8th: BHPOC Operations sub-committee
  - March 13th: BHPOC

- By April 1st: Finalize recommendations based on stakeholder feedback

Draft Recommendations

Straw Model – Reflects Draft Recommendations to Elicit Stakeholder Feedback before Presenting to Sister Agencies, Commissioner & OPM for a Final Recommendation

Licensed Behavioral Health Practitioners

- Potential funding for discussion purposes: $2 million out of $5 million

Billing/Procedure Code	Description
90791	Psychiatric Evaluation
90832	Psychotherapy (30 minutes)
90834	Psychotherapy (45 minutes
90837	Psychotherapy (60 minutes)
90847	Family therapy w/ patient

Licensed Behavioral Health **Clinics**

- Potential funding for discussion purposes : $3 million out of $5 million

Billing/Procedure Code	Description
90791	Psychiatric Evaluation
90832	Psychotherapy (30 minutes)
90834	Psychotherapy (45 minutes)
90837	Psychotherapy (60 minutes)
99211-99215	Evaluation/Mgmt. (medication mgmt.)
H2019	Home-based Services (Children)
T1017	Case Management w/ Home-Based (Children)
90847	Family therapy w/ patient
90853	Routine Group Therapy
S9480	MH IOP
H0015	SUD IOP (consider under SUD reinvestment)

Autism Spectrum Disorder (ASD) Services

- The Department plans to review payment policies for several of the ASD service codes and plans to modify policies that will result in a higher direct service reimbursement rate
  - Example 1: Data shows that youth are receiving a significant number of assessments within a calendar year
    - DSS plans to issue revised policy on the number of assessments that can be done in a calendar year and, based on estimated savings on assessments, redirect those savings into the direct service rates
  - Example 2: The ASD evaluation rate appears to be significantly higher than the Five State benchmark. DSS will review that rate as part of this process to determine if a portion of that reimbursement should be redirected to the direct service rate

Behavioral Health APPENDIX

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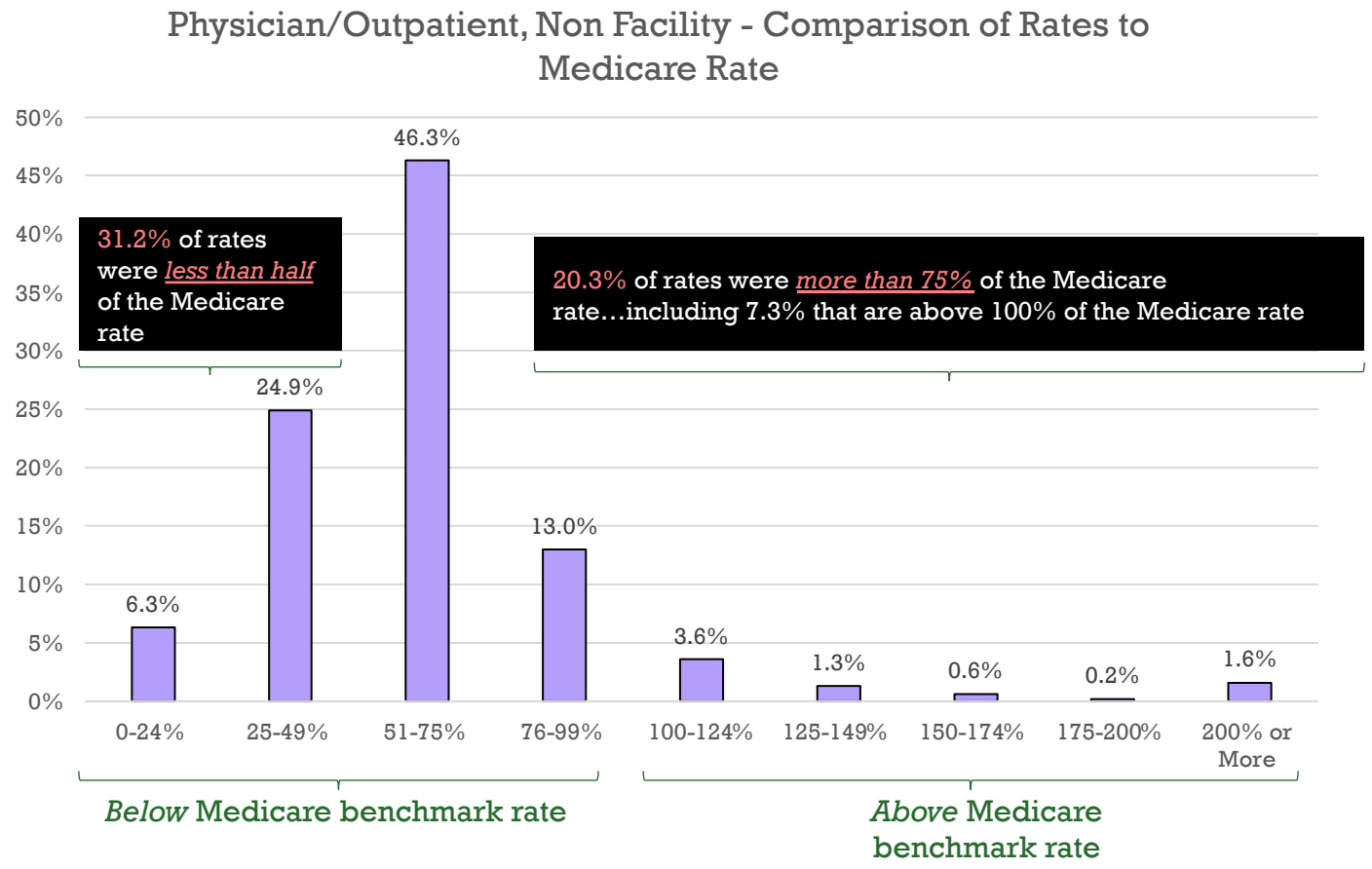

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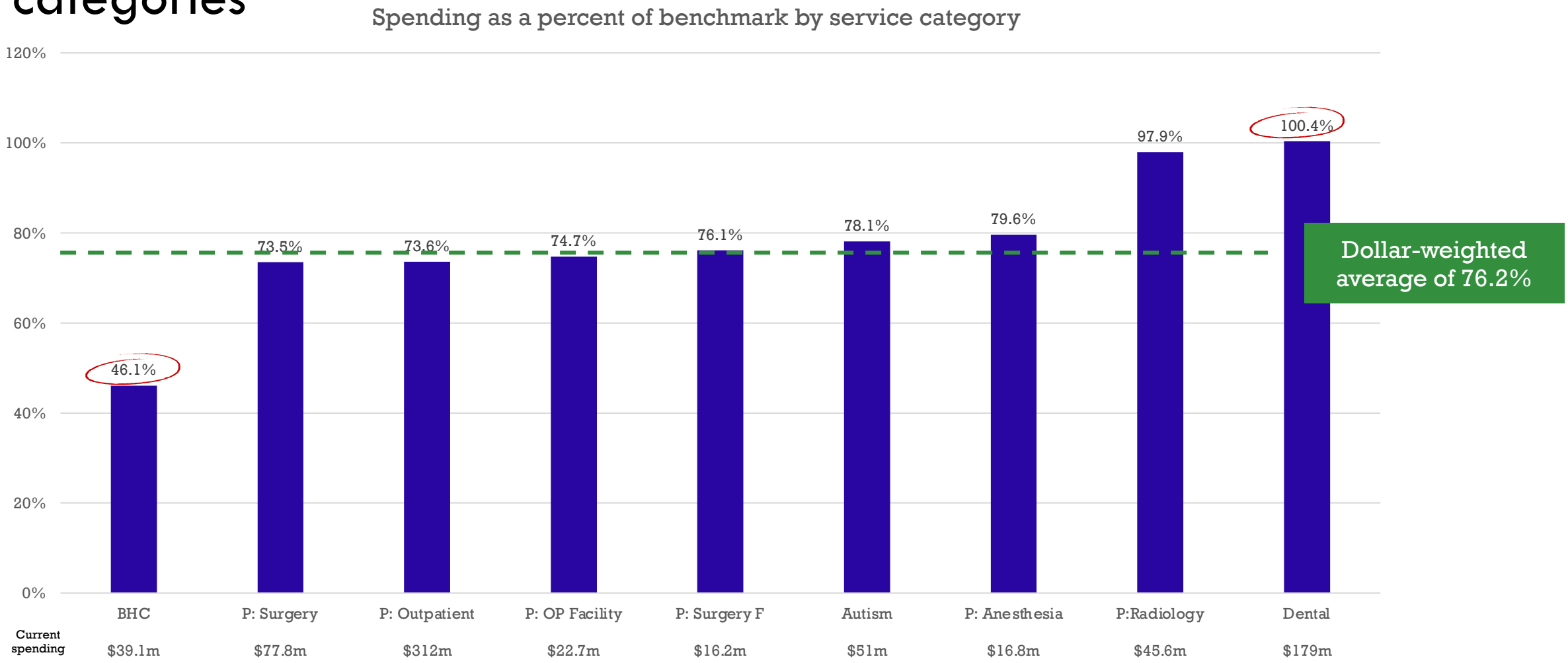

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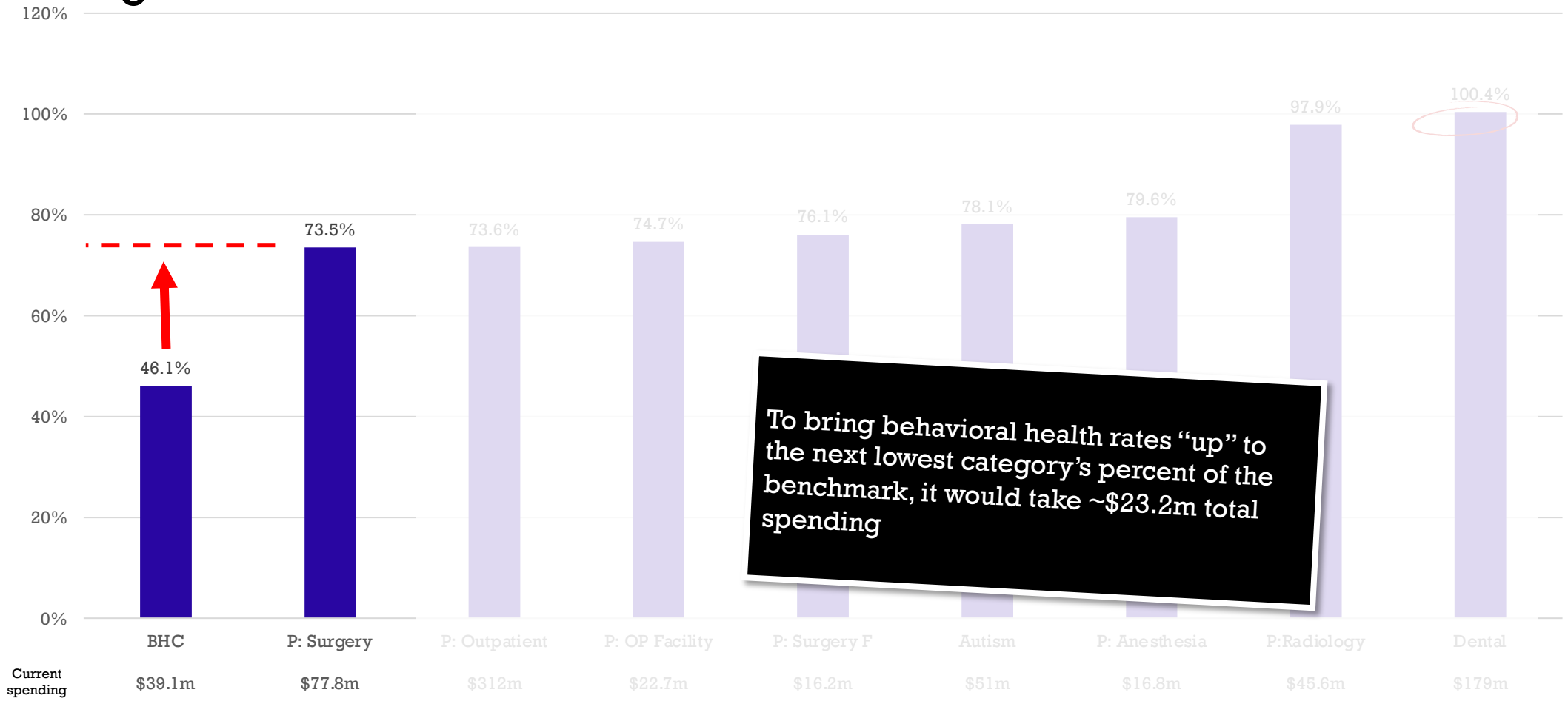

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