Rate Study: Phase 1

Executive Summary

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

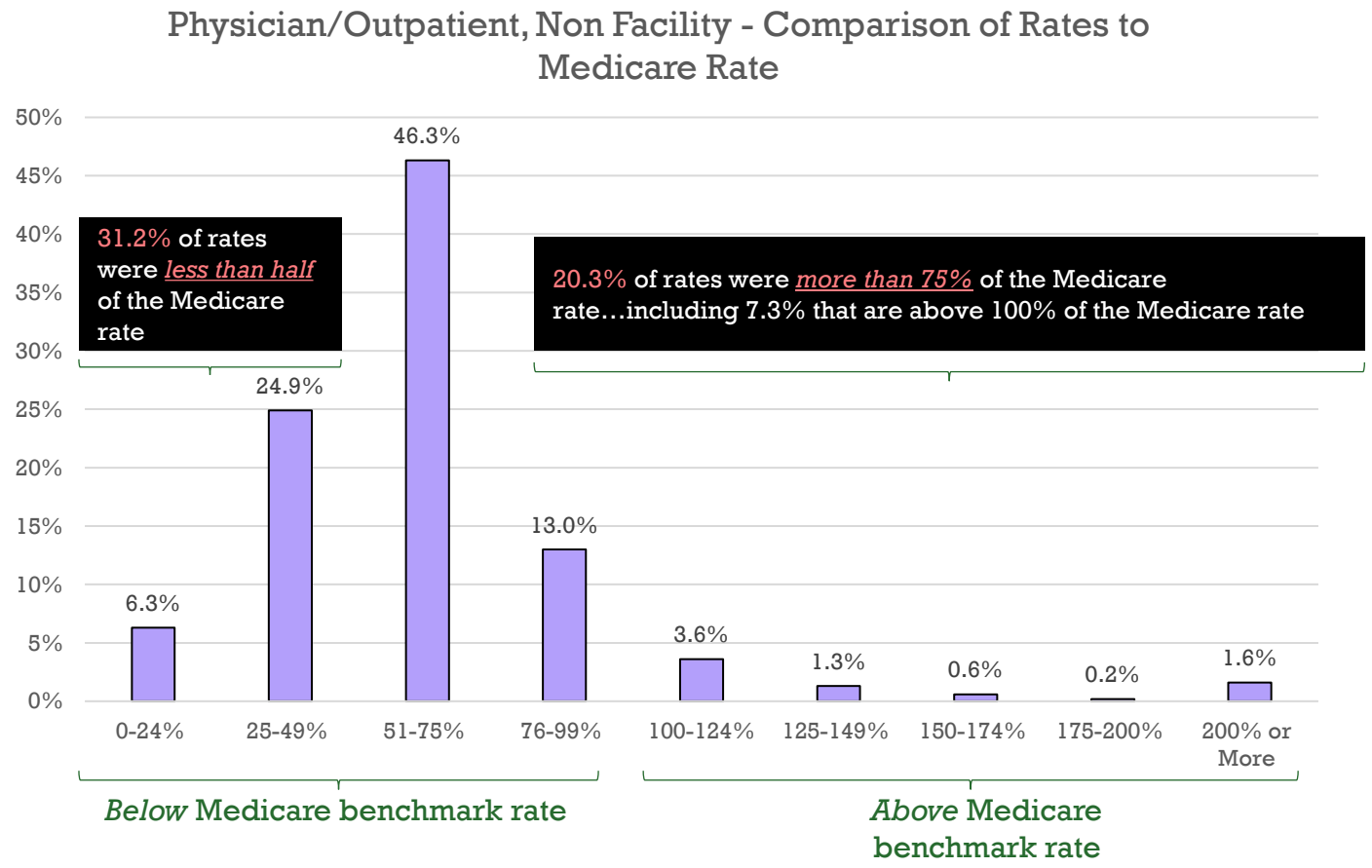
(2). Make recommendations regarding rate adjustments within available resources appropriated in the enacted budget ($7 million state share)

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

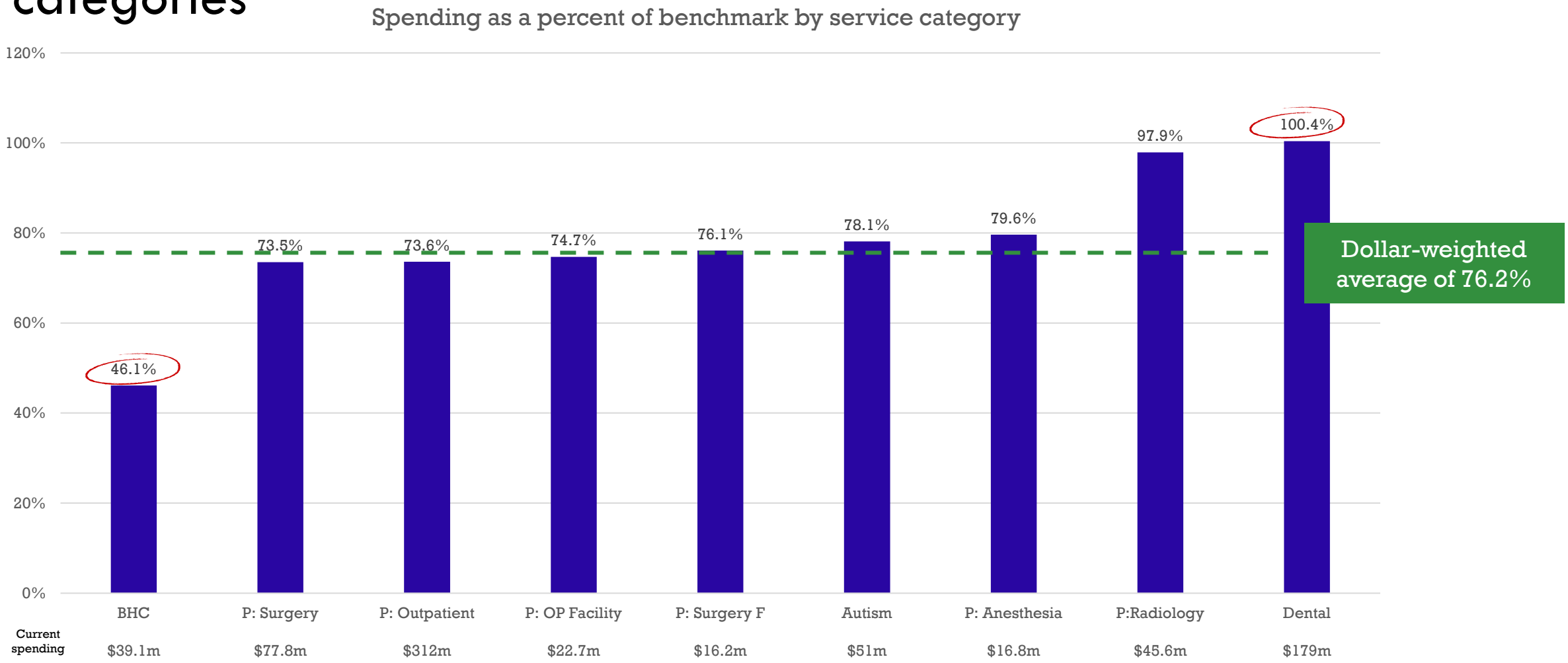
Example: Consider Physician/Outpatient (the largest service category). Here, for non-facility codes, the average comparison to Medicare was 65.3%...but there is large amount of variation around that average



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

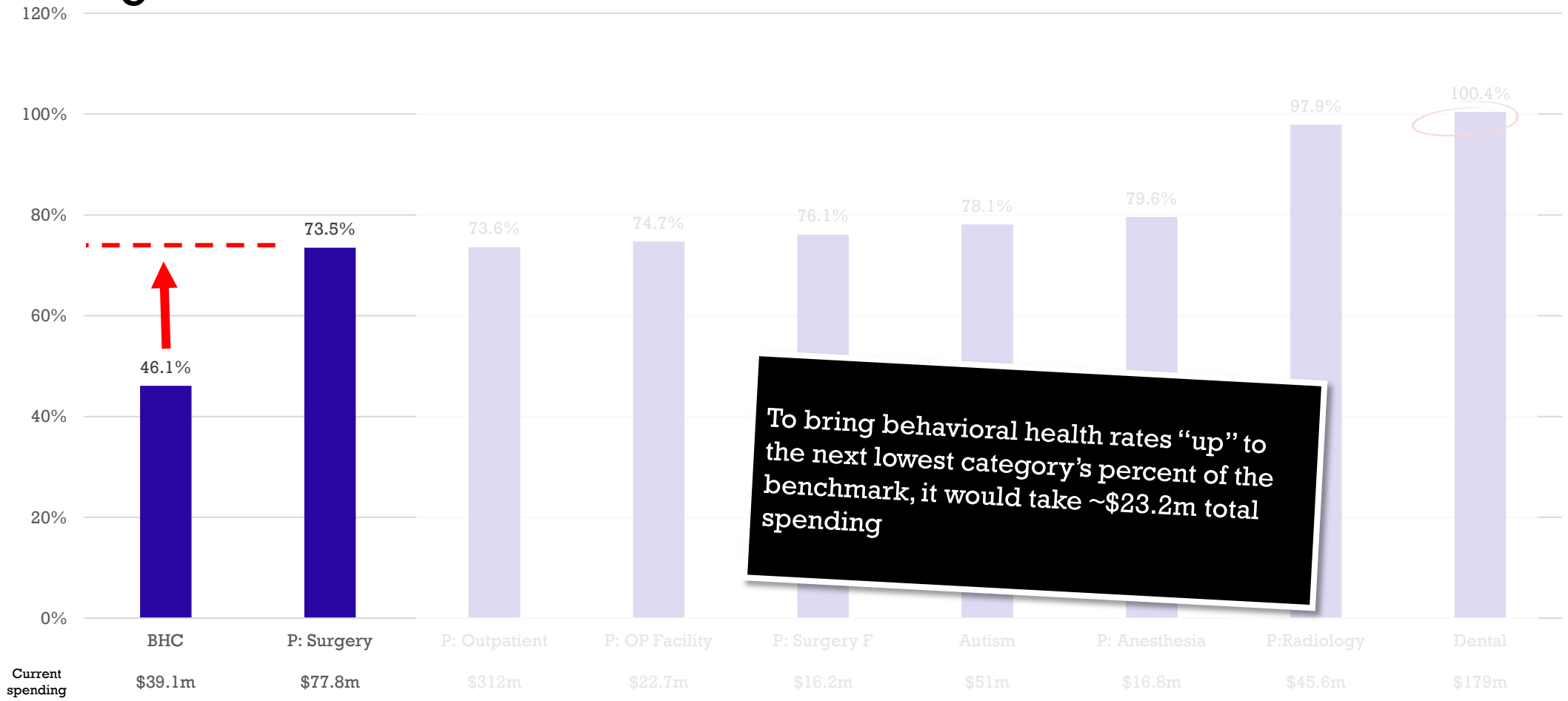


Notes: BHC is "Behavioral Health Clinic". "P:" means "Physician". "F" means facility

[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