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Substance Use Disorder Fee-For-Service Fee Development

State of Connecticut

Ambulatory Services

June 2022
Mercer Government Human Services Consulting

Fee-For-Service (FFS) Payments

A FFS fee is a set amount for each service procedure code paid by Connecticut to a provider for a delivered service

Service Description

Policy and clinical staff develop the service description outlining the service interventions and practitioner qualifications for delivering those interventions.

Payment Amount

Financial staff set rates for the expected average provider costs for those interventions by qualified providers.

Efficiency

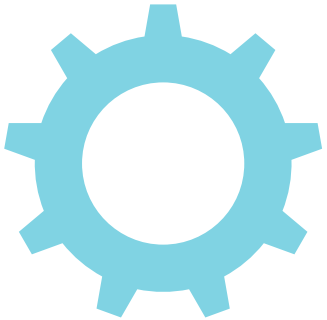
Strategically consider how to incent cost-effective treatments for specified populations.

CMS Requirements
FFS Rate Setting

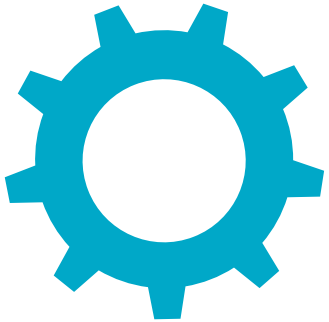
1

Medicaid Reimbursement

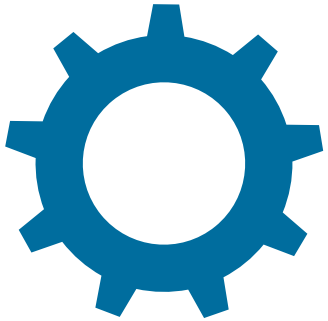
- Medicaid is a complex federal/state program where the federal government partially funds state medical services meeting certain federal requirements.
- CMS enters into a contract (a “State Plan”) with the state defining the exact beneficiaries receiving services from providers meeting specified qualifications.
- Medicaid reimbursement hinges on these three components:



Eligible beneficiary is covered in State Plan



Eligible service is covered in State Plan



Eligible provider meets qualifications in the State Plan

Medicaid Reimbursement

- Medicaid/Medical Assistance (MA) reimbursement compensates for services meeting federal definitions and requirements.
- In addition, state-set reimbursement should include consideration for:
  - Overall system goals and strategies to promote cost-effective care
  - Intended delivery and desired outcomes of the service
  - Ensuring payment fees are sufficient to enlist enough providers and are not excessive to incentivize over- or under-utilization of other services

Medicaid Reimbursement

Federal regulations at 42 CFR Part 447 provide regulatory guidance for service payments made by the states using Medicaid funds. The regulations are broad-based to allow states to establish different payment options in their Medicaid services and programs.

Reimbursement for Medicaid FFS services are based on each services' provider qualifications that are required to deliver the services as defined in the State Plan.

Medicaid Reimbursement

Broad rate-setting requirements:

Payments must be sufficient to attract enough providers such that services are readily available to beneficiaries (42 CFR 447.204)

Payments must be consistent with efficiency, economy and quality of care (42 CFR 447.200)

Each service must be sufficient in amount, duration and scope to achieve its purpose (42 CFR 440.230)

Public notice is required for any significant change in FFS methodology or standards for setting payment rates for services (42 CFR 447.205). CMS interprets this as any change in FFS rates

Medicaid Reimbursement

What influences reimbursement?

Provider qualifications are the primary determinant of FFS provider rates

Service definitions and medical necessity criteria influence the provider qualifications, indirect costs and non-productive time (e.g., caseload, supervisor to staff ratios, etc.)

Costs associated with service delivery (e.g., training and oversight, travel, occupancy, administration, etc.)

CMS Reimbursement Principles

Fee schedule or cost-based rates need to consider:

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- Direct costs of services to be utilized
- Indirect costs associated with service delivery
- General administration
- Non-MA/Non-Medicaid activities
- How billed time does not exceed available productive time
- Single rates exclude differently licensed practitioners

The next section will outline these components in the Connecticut ASAM context.

CMS Reimbursement Principles

State Plan

- State plans are written for discrete services reimbursed using FFS methodologies.

FFS

- The FFS payment methodology must be based on the unit of service to be paid.

State Plans

State plans are written for discrete services reimbursed using FFS methodologies.

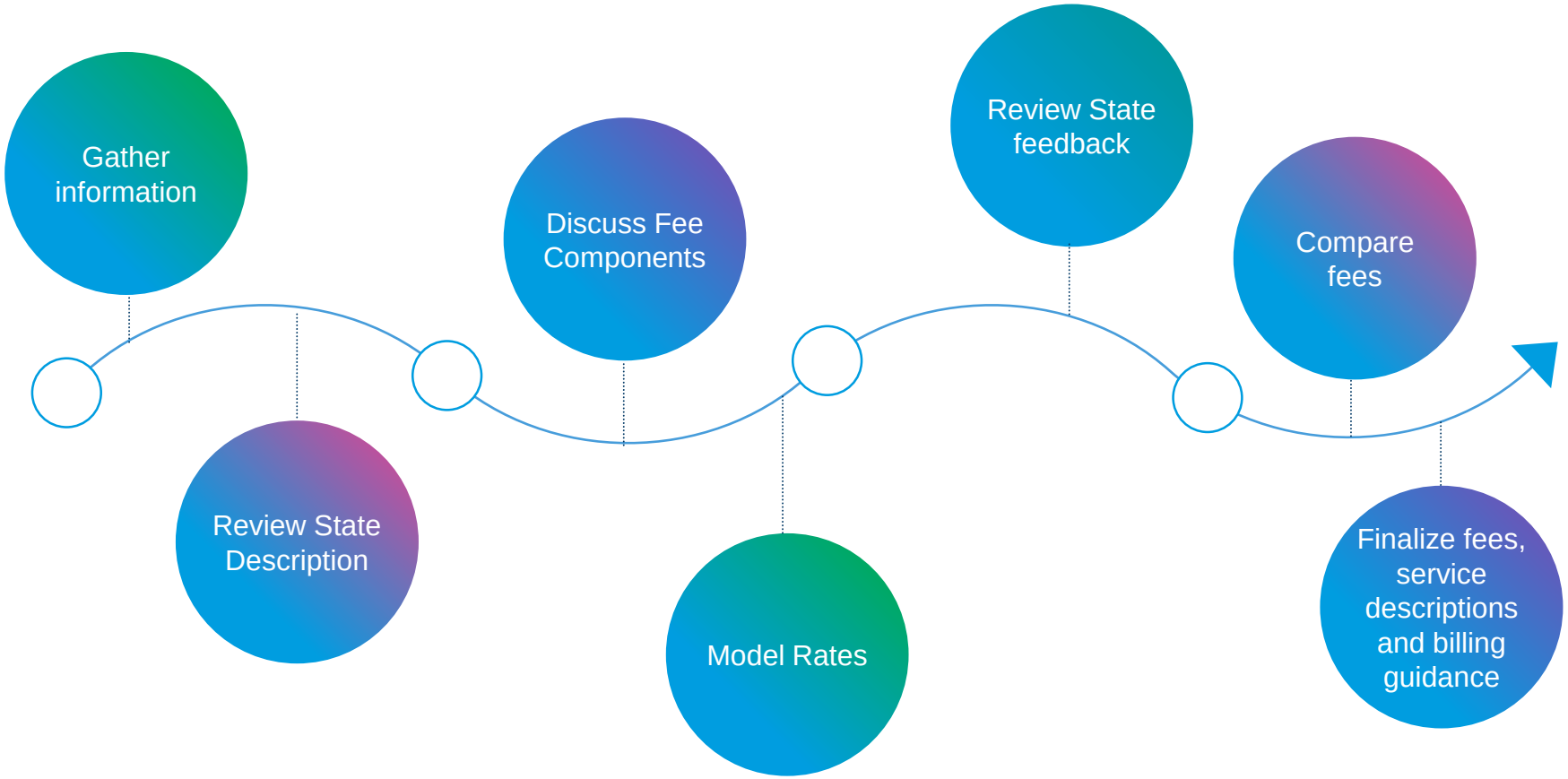
Unit Cost

The FFS payment methodology must be based on the unit of service to be paid.

FFS Fee Development Process

2

Process for Developing FFS Fees



Process for Developing FFS Fees

What are the expected service outcomes?

What are the national models and service standards, and how have they been implemented (or how will they be implemented in CT)?

What constitutes a billable service?

Which costs are included for each service?

A critical component of the rate development process is clarifying the service definitions

Process for Developing FFS Fees

Policy Perspective

- Ensure CMS participation in funding via compliance with federal requirements
- Ensure compliance with state regulations and requirements

Clinical Perspective

- Ensure service is designed to achieve clinical results, both for the individual service and across the system of care

Financial Perspective

- Ensure assumptions incent behaviors that meet clinical objectives and meet CMS requirements:
  - Fees priced too low will hinder provider recruitment and service utilization
  - Fees priced too high may attract provider base, but may not achieve clinical results

Fee Assumptions and Development
CMS Reimbursement Principles

Fee schedule rates include consideration for

- Direct costs of services to be utilized (e.g., wages of practitioners delivering the service)
- Indirect costs (e.g., wages of supervisors)
- General administration
- Costs for non-MA activities were excluded
- How billed time does not exceed available productive time
- Single rates exclude differently licensed practitioners

Reimbursement

- Relevant federal reimbursement principles that are applicable in determining rates paid to providers, when those rates are established under a FFS program

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Treatment Fees

- ASAM specifies national standards related to service delivery, staffing, training and certification.
- *State stakeholders recognized where the service design and delivery envisioned for Connecticut was different than the national models and discussed whether or not that was appropriate given overall system goals.*
- Staffing requirements used in fees generally align with Connecticut's staffing standards for each ASAM level of care. Significant component of the fee is the cost of the direct care worker providing the services.

ASAM 2.1 Intensive Outpatient Treatment Program (IOP)

ASAM 2.5 Partial Hospitalization Program (PHP)

ASAM 1-WM*

ASAM 2-WM*

***provided in conjunction with other ambulatory levels of care**

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Financial Decisions

- Wages to pay practitioners
  - Compensation data was sourced from the Bureau of Labor Statistics representative of wages paid in the Bridgeport-Stamford-Norwalk metropolitan area
  - Mercer performed reasonability checks of average wages and wage ranges by comparing to compensation studies on similar positions in other regions of Connecticut
  - Wages were adjusted upwards to reflect additional trend consideration
- Benefits to allow/employee-related expenses (ERE)
  - Health insurance, federal and state unemployment taxes, Workers' Compensation, Federal Insurance Contributions Act, and other benefits (e.g., long-term and short-term disability, retirement benefits)
- Fee structure/number of fees
- Training expenses to include
- Components of service delivery that reduce productivity
- General and administrative allowances
- Program changes

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Additional Costs Included in Treatment Fees

Costs associated with direct service, but not directly billable include items such as

- ERE
- Cost of materials or equipment required to deliver the service
- Cost of training and other expenses incurred specifically to carry out the service
- Cost of required supervision of direct care practitioners and part-time workers

Costs associated with service delivery aligning with ASAM

- Training expenses related to the initial and ongoing training costs for each team
- Direct program costs
- The rates were designed to align with provider standards and individualized treatment plans

Costs associated with general administrative expenses include items such as

- Salaries of staff supporting the provision of service/other staff support
- Insurance expenses

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Other Considerations

ASAM 2.1 and ASAM 2.5

- A biopsychosocial assessment is required under ASAM
- 90791 prior to or at the time of admission is billed separately
- 90792 may be billed separately at any time

ASAM 1-WM and ASAM 2-WM

- ASAM 1-WM reflects an hourly rate that can be billed up to 4 hours
- ASAM 2-WM reflects the per diem rate between 4 and up to 24 hours of service delivery under this level of care
- ASAM 1-WM and ASAM 2-WM are billed in addition to ambulatory treatment services
- The State intends to monitor ambulatory withdrawal management services for under- and over-utilization

All LOCs

- The treatment fees reflect care coordination resources necessary under ASAM, which the provider may staff as appropriate and needed
- It is expected that the assessed needs of the beneficiary will be addressed through treatment in an individualized manner

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Final Fees

Service	Rate Type	Fee
ASAM 2.1 - Intensive Outpatient Program (IOP)	Per Diem	$173.62
ASAM 2.5 - Partial Hospitalization Program (PHP)	Per Diem	$184.82
ASAM 2-WM - between 4 and up to 24 hours	Per Diem	$442.70
ASAM 1-WM - up to four hours	Hourly	$110.67

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