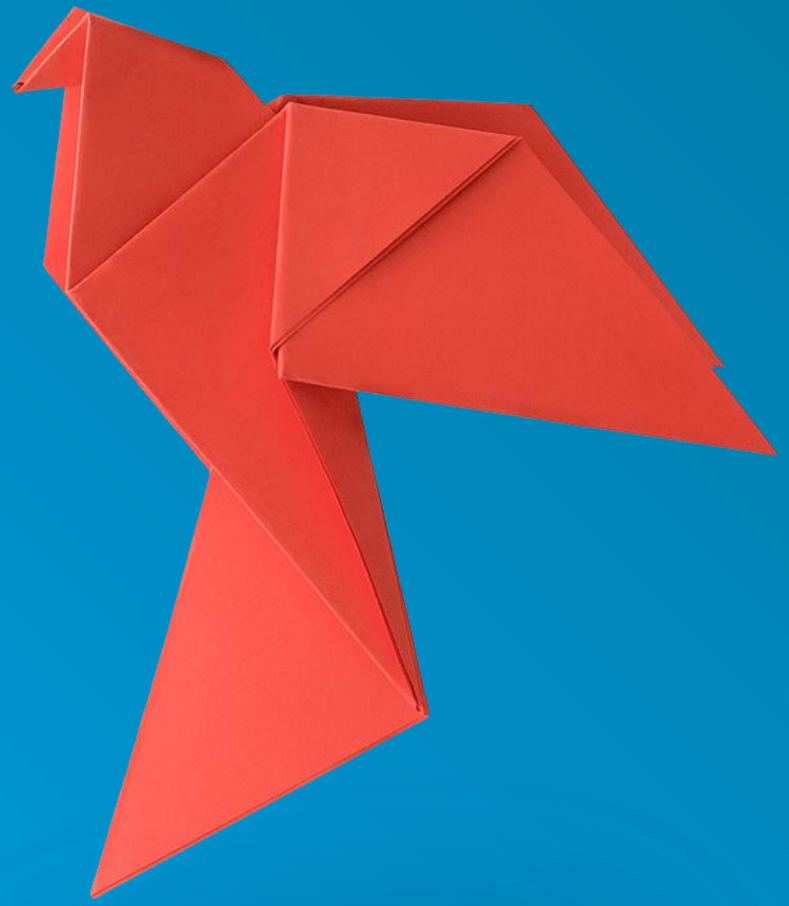
Mercer

State of Connecticut

Substance Use Disorder Fee-For-Service Fee Development



June 10, 2021

Mercer Government Human Services Consulting
Phoenix

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

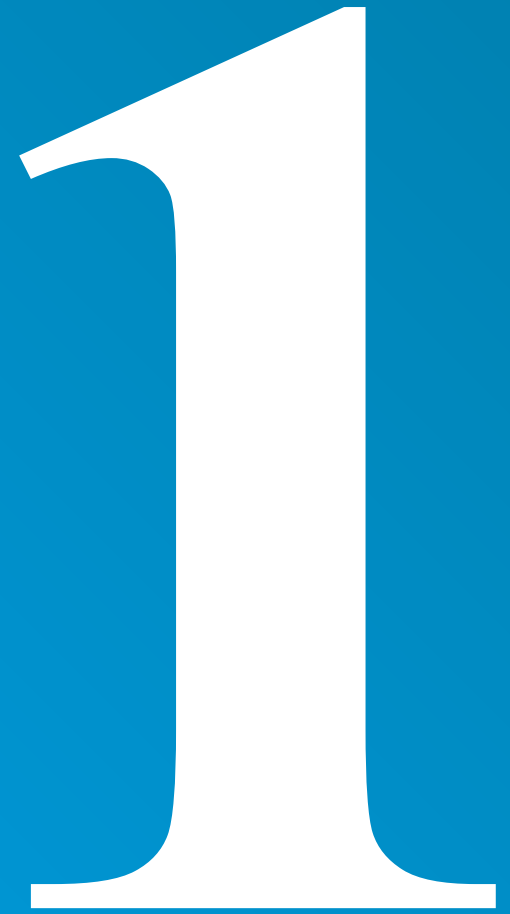
Financial staff set rates for the expected average provider costs for those interventions by qualified providers.

Efficiency

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

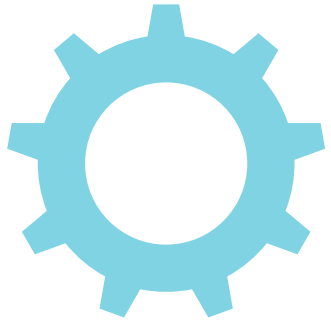
CMS Requirements

FFS Rate Setting

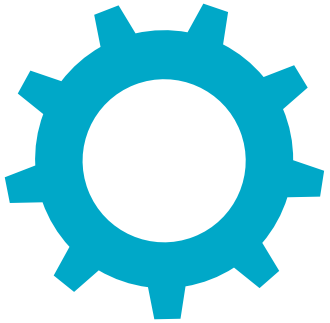


Medicaid Reimbursement

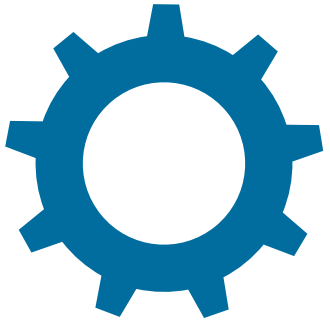
- Medicaid is a complex federal/state program where the federal government partially funds state medical services meeting certain federal requirements.
- CMS enters into a contract (a “State Plan”) with the state defining the exact beneficiaries receiving services from providers meeting specified qualifications.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

Fee schedule or cost-based rates need to consider:

- 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.

VBP

- The State may lay out a value-based purchasing payment methodology.

State Plans

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

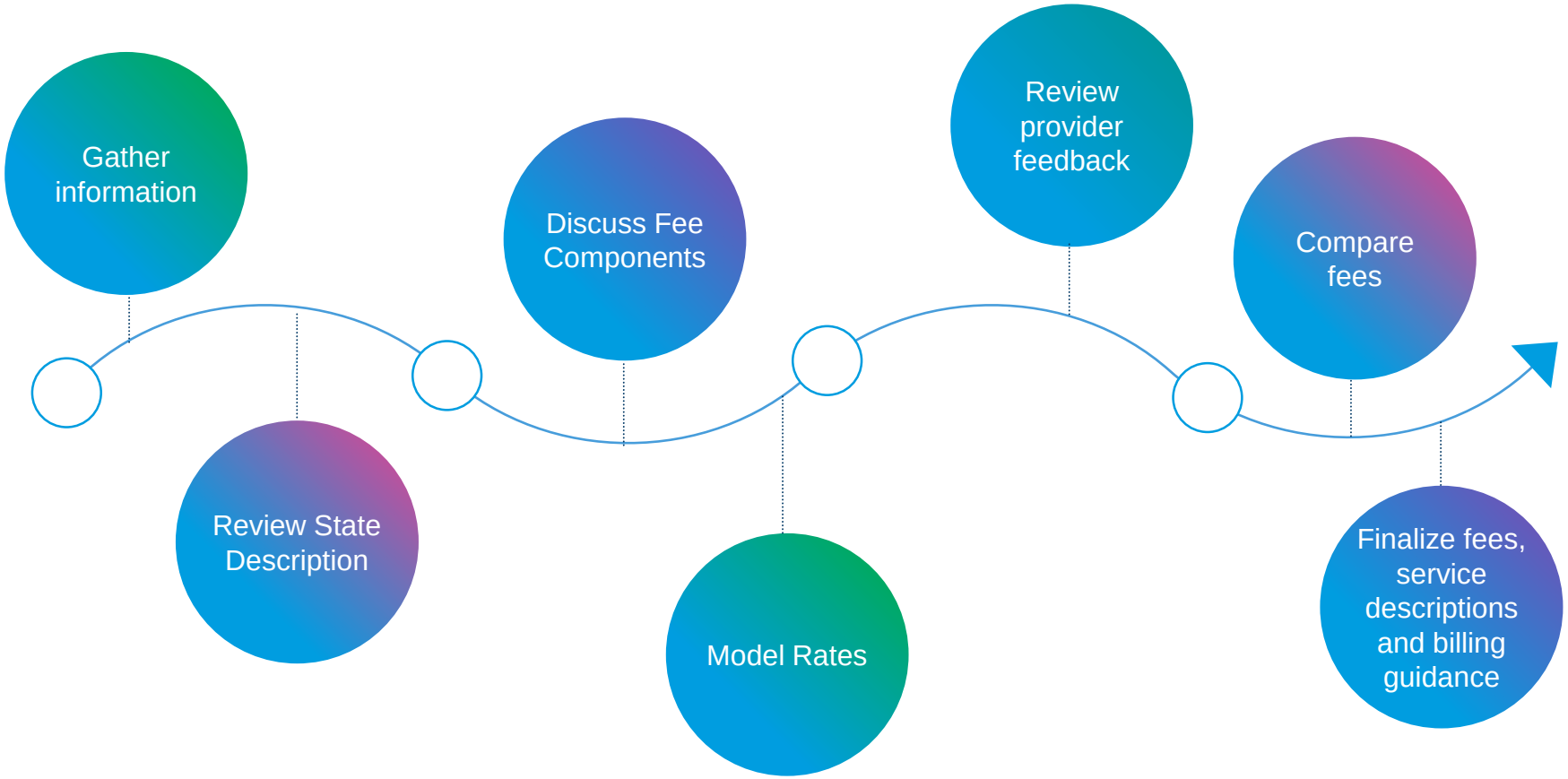
Unit Cost

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 considered

- 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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SUD ASAM Residential Services

SUD ASAM Residential Services

Treatment Fees

- For ASAM, there are 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 model and discussed whether or not that was appropriate given overall system goals.*

Room and Board Fees

- Room and Board fees were developed separately from treatment fees, as Medicaid will not cover non-treatment costs.
- *Mercer utilized state-specific benchmarks during development of Room and Board assumptions.*

SUD ASAM Residential Services
Treatment Fees

- Staffing requirements used in fees 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.
- Financial decisions in this process:
  - Wages to pay practitioners
  - Benefits to allow
  - Fee structure/number of fees
  - Training expenses to include
  - Components of service delivery that reduce productivity
  - General and administrative allowances
- May 2020 Compensation data was taken from the Bureau of Labor Statistics, which is 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

SUD ASAM Residential Services
Treatment Fees

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

- Employee Related Expenses (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

ERE may include the following

- Health insurance
- Federal and state unemployment taxes annual cost
- Workers' compensation
- Federal Insurance Contributions Act
- Other benefits, such as long-term and short-term disability, retirement benefits, etc.

For ASAM, the following costs are included to ensure fidelity to the model:

- Training expenses related to the initial and ongoing training costs for each team
- Direct program costs (such as for supplies, icups, etc.)
- 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

Mercer

SUD ASAM Residential Services
Room and Board Fees

- State-only expense (not covered by Medicaid) to recognize non-treatment related costs for an individual at a Residential facility
- Financial considerations:
  - Rent and Utilities
  - Maintenance
  - Food costs
  - Transportation costs for non-treatment related trips
  - General and administrative allowances
  - Recognition of increased expenses for Pregnant and Parenting Women level of care, such as child care and increased food costs

SUD ASAM Residential Services
Provider Feedback

ASAM 3.5

Providers suggested including a RN on day shift for this level of care

ASAM 3.7RE

Providers suggested revising standards for third shift nurses

ASAM 3.7WM

Providers outlined areas where current staffing patterns vary from standards

All LOCs

Providers suggested including two staff on for all shifts

SUD ASAM Residential Services

DSS developed a per diem rate for ASAM levels of care based on the staffing requirements for each level and relevant ERE, administrative, and other costs.

For complete listing of the assumptions utilized in the rate development process, please refer to the Clinical Assumptions Grid.

For fees by facility capacity and level of care, please refer to the ASAM Fees and Tiers exhibit. Note that the rates are subject to additional review and revision.