Wisconsin Department of Administration
Division of Executive Budget and Finance

Fiscal Estimate - 2015 Session

☒ Original ☐ Updated ☐ Corrected ☐ Supplemental

LRB Number **15-2837/1**	Introduction Number **AB-0713**

Description
Access to and prior authorization for mental health services under the Medical Assistance program

Fiscal Effect

State:
- ☐ No State Fiscal Effect
- ☐ Indeterminate
  - ☐ Increase Existing Appropriations
  - ☐ Decrease Existing Appropriations
  - ☐ Create New Appropriations
  - ☐ Increase Existing Revenues
  - ☐ Decrease Existing Revenues
  - ☒ Increase Costs - May be possible to absorb within agency's budget ☐ Yes ☒ No
  - ☐ Decrease Costs

Local:
- ☐ No Local Government Costs
- ☐ Indeterminate
  1. ☐ Increase Costs ☐ Permissive ☐ Mandatory
  2. ☐ Decrease Costs ☐ Permissive ☐ Mandatory
  3. ☐ Increase Revenue ☐ Permissive ☐ Mandatory
  4. ☐ Decrease Revenue ☐ Permissive ☐ Mandatory
  5. Types of Local Government Units Affected
     ☐ Towns ☐ Village ☐ Cities ☐ Counties ☐ Others ☐ School Districts ☐ WTCS Districts

Fund Sources Affected
☐ GPR ☐ FED ☐ PRO ☐ PRS ☐ SEG ☐ SEGS

Affected Ch. 20 Appropriations

Agency/Prepared By	Authorized Signature	Date
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Fiscal Estimate Narratives

DHS 2/1/2016

LRB Number **15-2837/1**	Introduction Number **AB-0713**	Estimate Type **Original**
Description Access to and prior authorization for mental health services under the Medical Assistance program		

Assumptions Used in Arriving at Fiscal Estimate

This Bill changes the prior authorization (PA) thresholds for mental health treatment provided under the Department's Medical Assistance (MA) program.

Specifically, this Bill would increase the threshold for requiring PA from the current 15 mental health therapy visits to 24 visits and from the current immediate requirement of PA for adolescent treatment to 15 days. Additionally, this Bill limits the collection of information on prior authorization forms for mental health services and creates a preferred provider status for processing prior authorization requests. This Bill also requires HMOs to use uniform application, provider recertification, and prior authorization formats and to allow mental health agencies to replace departing mental health professionals with another of similar qualifications.

Each of these provisions would have fiscal impacts on the Department.

Prior Authorization Thresholds for Mental Health Therapy
Presently, Medicaid fee-for-service (FFS) members are allowed to receive $825 or 15 hours of mental health therapy visits before requiring prior authorization. This Bill would increase the PA threshold to 24 visits.

In calendar year (CY) 2014, 51,000 fee-for-service (FFS) Medicaid members received outpatient mental health services (therapy), 92 percent of whom received $825 or less of services and 94 percent of whom received 15 hours or fewer of services. In CY 2014, 98 percent of FFS members would have received their services before reaching the PA threshold in this Bill. Altogether, the State made $15 million payments (AF) for FFS Medicaid members' outpatient mental health services; the average cost per member was $292.

Mental health therapy use in Medicaid HMO claims is similar to use by FFS members. Of the 64,000 Medicaid HMO members who received outpatient mental health services, 94 percent received 15 hours or fewer of services and 98 percent received 24 hours or fewer of service. Altogether, Medicaid HMOs made $26 million in payments for their Medicaid members' outpatient mental health services; the average cost per member was $402.

Increasing the number of mental health therapy days allowable before requiring prior authorization may have the effect of increasing utilization of mental health therapy services. This may occur in two ways. First, FFS members might have ended treatment prematurely because they did not want to go through PA. However, 87 percent of FFS members ended treatment at or before 10 hours, suggesting that it is unlikely that a 15 hour threshold was significantly inhibiting service utilization.

The second way in which utilization may increase is through members who continue receiving services under the proposed threshold who would have been denied under the current threshold. In 2015, the Department denied 71 of 8,894 prior authorization claims for mental health services. The number of 71 denials underestimates services that are affected by PA since some PA requests will simply not be pursued during the process when providers are asked for additional information. Also, the presence of PA and the knowledge of PA standards may deter requests for services, sometimes referred to as the sentinel impact. Due to the potential sentinel impact, the fiscal impact of increasing the adult mental health therapy threshold is uncertain, but a tentative estimate is an impact of $100,000 AF to $500,000 AF ($42,000 to $210,000 GPR) per year.

The Department does not monitor PA done by HMOs, requiring only that HMO services match or exceed FFS benefits. Therefore, the threshold change may or may not impact service utilization for HMOs.

Prior Authorization Thresholds for Adolescent Day Treatment
Prior authorization is currently required for all adolescent day treatment which is a service that provides up to 5 hours per day and 25 hours per week of treatment. This Bill would allow 15 days of service prior to requiring PA, which would be a maximum of 75 hours. On average, children utilizes 3.6 hours of treatment per day at an average cost of $32 per hour, which for 15 days would total 54 hours of treatment at an approximate total cost of $1,728.

In CY 2014, 955 FFS Medicaid and 1,172 HMO Medicaid members received adolescent day treatment services. Fee-for-service claims totaled $5.0 million, and HMO claims totaled $4.3 million, in payments to day treatment providers. FFS members' average utilization of day treatment services was 162 total hours, with an average of 3.6 hours per day for an average of 45 days in the calendar year, and at an average total cost of $5,260 per member. For HMO members, the average utilization was 112 hours and an average cost of $3,712.

Raising the threshold for adolescent day treatment PA may result in increased utilization of day treatment services in two ways. First, members who may have never previously sought this service may cause utilization and costs to increase. These users may include both individuals for whom day treatment services are appropriate and those for whom day treatment is not. However, the size of this sentinel impact is uncertain. If it is assumed that the sentinel impact deters 5% of potential utilizers, the fiscal impact would be $250,000 AF ($105,000 GPR) annually.

Second, utilization may increase by those members who had prior authorizations previously denied. In 2015, there were 112 members whose PA for adolescent day treatment was denied. Assuming these individuals would receive the services up until they reach the new PA threshold, the estimated cost increase is $273,000 AF ($115,000 GPR) annually.

As mentioned previously, the Department does not monitor PA done by HMOs, requiring only that HMO services match or exceed FFS benefits. Therefore, the threshold change may or may not impact service utilization for HMO.

Collection of Prior Authorization Information
There are also one-time administrative costs associated with the changes in prior authorization forms described in this Bill. The limitation of information on the prior authorization forms for mental health services would require adjustments to the current forms used. The Department estimates the amount of time required to modify these forms at 500 hours which would have an approximate one-time cost of $50,000 AF ($25,000 GPR).

Creating a Preferred Provider Status
Creating a preferred provider status for mental health services would require changes to the Departments processing of mental health providers' prior authorization requests. The Department estimates this change would require 1,500 hours to implement and one permanent FTE to administer. The one-time design costs would be approximately $150,000 AF ($75,000 GPR) while the FTE would cost approximately $90,000 AF ($45,000 GPR) .

Furthermore, creating a preferred provider status which effectively eliminates PA requirements for those providers who meet the criteria may have the effect of increasing those providers' claims for mental health services. The mental health services which would be covered under this provision are: adult mental health day treatment, child/adolescent day treatment, health and behavior interventions, outpatient mental health services, outpatient substance use services, and substance abuse day treatment. Presently, the total Medicaid FFS expenditures in these categories are $30 million AF, including the $15 million in outpatient mental health services and $5 million in child/adolescent day treatment described previously.

There is uncertainty as to what percentage of providers would meet the preferred provider status since it will depend on how "percentage of approved PAs" is defined. There would be issues on how to handle PA requests that are not completed or are modified. Also, it is uncertain the extent to which, if any, mental health service claims would increase from these providers. Although uncertain, the impact on utilization of mental health services could be significant. If it is assumed that utilization of mental health services increases by 5%, the fiscal impact would be $1,500,000 AF ($630,000 GPR) annually.

Change in Volume of Prior Authorizations Requests and Retrospective Reviews
The several components of this Bill will likely change the number of prior authorizations for FFS mental health and adolescent day treatment services the Department processes. The Department is responsible for processing PA requests, either with in-house or contracted staff. With the increased threshold for PA for

mental health therapy and adolescent day treatment, there will likely be a decrease in PA request volume. There will also be a reduction in PA reviews from the creation of a preferred provider status.

In 2015, the Department received approximately 9,000 PA requests for mental health therapy visits and approximately 1,500 PA requests for adolescent day treatment. Under the proposed PA threshold, the number of PA requests for these two classes of service is expected to decrease by 6,500.

Providers of any of the seven types of mental health service requiring PA (listed previously) under the Medical Assistance program, which would be entitled to the preferred provider status under this Bill, would further reduce the PA request volume. Those who have been granted preferred provider status would see all of their PA requests processed immediately, in a manner similar to claims made for services not requiring PA. It is uncertain the number or fraction of providers who would seek, and be approved for, preferred provider status. Thus, the total reduction in PA requests that would be reduced is uncertain. However, the impact is likely to be significant, and it may be that an additional 5,000 PA requests are avoided.

The Department undertakes retrospective reviews of claims to ensure they were medically necessary and reduce the opportunity for fraud, waste, and mismanagement. The PA threshold increase for services requiring PA and the creation of a preferred provider status for mental health therapies will require the Department to increase the number of retrospective reviews of mental health services to insure integrity in the claims process. Costs associated with retrospective reviews will increase, cancelling out any cost savings observed with reductions in PA request volume.

HMO requirements
Requiring uniform application, provider recertification, and prior authorization forms and processes of HMOs that provide payment for services through the Department's MA programs will increase HMO's administrative costs. The Department estimates an administrative rate increase of 1 to 3 percent would be necessary to pay for these changes. This equates to between $15.5 million (AF) ($6.2 million GPR) and $46.5 million (AF) ($18.6 million GPR).

Summary
The total estimated fiscal impact of this Bill is 33,600,000 AF (13,500,000 GPR), of which 31,200,000 AF (12,500,000 GPR) are one-time costs. The attached table summarizes the estimated costs for each component of this Bill.

Long-Range Fiscal Implications

Bill Component	Estimated Ongoing Costs		Estimated One-Time Costs	
	AF	GPR	AF	GPR
Adult Therapy Threshold	$300,000	$142,000	--	--
Adolescent Day Treatment Threshold	$523,000	$220,000	--	--
System Changes for New Thresholds Info	--	--	$50,000	$25,000
Creating Preferred Provider Status	1,590,000	675,000	150,000	75,000
PA Volume / Retro reviews	0	0	--	--
HMO requirements			$31,000,000	$12,400,000
Total	**$2,413,000**	**$1,037,000**	**$31,200,000**	**$12,475,000**

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Fiscal Estimate Worksheet - 2015 Session

Detailed Estimate of Annual Fiscal Effect

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Description
Access to and prior authorization for mental health services under the Medical Assistance program

I. One-time Costs or Revenue Impacts for State and/or Local Government (do not include in annualized fiscal effect):

The one-time costs are $31,200,000 AF ($12,475,000 GPR). This number includes system changes for prior authorization information collection, the creation of preferred provider status for mental health services, and administrative payments to HMOs.

II. Annualized Costs:	**Annualized Fiscal Impact on funds from:**	
	Increased Costs	Decreased Costs
A. State Costs by Category		
State Operations - Salaries and Fringes	$	$
(FTE Position Changes)		
State Operations - Other Costs	90,000	
Local Assistance		
Aids to Individuals or Organizations	2,323,000	
TOTAL State Costs by Category	**$2,413,000**	**$**
B. State Costs by Source of Funds		
GPR	1,037,000	
FED	1,376,000	
PRO/PRS		
SEG/SEG-S		

III. State Revenues - Complete this only when proposal will increase or decrease state revenues (e.g., tax increase, decrease in license fee, ets.)

	Increased Rev	Decreased Rev
GPR Taxes	$	$
GPR Earned		
FED		
PRO/PRS		
SEG/SEG-S		
TOTAL State Revenues	**$**	**$**

NET ANNUALIZED FISCAL IMPACT

	State	Local
NET CHANGE IN COSTS	$2,413,000	$
NET CHANGE IN REVENUE	$	$

Agency/Prepared By	**Authorized Signature**	**Date**
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