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Physician and Behavioral Health Services (Health Services -- Medical Assistance)

[LFB 2019-21 Budget Summary: Page 172, #10]

CURRENT LAW

The medical assistance (MA) program pays certified health care providers for primary, preventive, acute, and long-term care services they provide to enrollees. These providers include individual practitioners as well as hospitals, nursing homes, and local governmental entities such as county human services departments and school districts. MA enrollees are entitled to receive covered, medically necessary services furnished by these providers. Eligibility for MA is based on meeting financial and/or disability status criteria.

GOVERNOR

Provide $22,471,900 ($8,732,800 GPR and $13,739,100 FED) in 2019-20 and $46,642,500 ($18,217,800 GPR and $28,424,700 FED) in 2020-21 to increase MA reimbursement rates for mental health, behavioral health, and psychiatric services provided by physicians and medical clinics. The funding in the bill is based on the administration's expectation that rates would be increased effective January 1, 2020.

DISCUSSION POINTS

1. MA pays health care providers, such as physicians, dentists, and hospitals, for services they provide to MA recipients. These payments are often referred to as "provider reimbursement," although in most cases the MA program pays a pre-established maximum fee, rather than an amount equal to the provider's usual and customary charges or the provider's cost of providing the service. Provider reimbursement occurs either on a fee-for-service (FFS) basis, or under a managed care model

through a health maintenance organization (HMO). FFS payments for most non-institutional services are generally based on a maximum fee schedule, which specifies the amount of the reimbursement by medical procedure code and type of provider. HMOs may establish their own reimbursement policies for contracted providers, although they generally follow the FFS schedule.

2. In contrast to maximum fee schedule rates for physicians and other non-institutional providers, the reimbursement rate methodologies used for hospitals and nursing homes are updated annually and include cost-based increases to a portion of the reimbursement formulas. The funding for these increases is provided in the biennial budget as part of MA cost-to-continue estimate. Any non-institutional provider increases must be either provided as part of separate budget decision items or implemented by the Department from within the existing budget for MA benefits.

3. The last broad-based increase to the maximum fee schedule for most non-institutional medical services occurred in 2008. Effective with services provided on July 1, 2008, rates for physician and clinic services, medical equipment and supplies, mental health and substance abuse services, physical, occupational, and other therapy services, and other professional services (dentistry, vision, chiropractic, podiatry, etc.) were increased by 1.0%. At the same time, reimbursement rates for evaluation and psychotherapy services provided by psychiatrists were increased by 20%.

4. Since the 2008 increases, there have been a few other reimbursement rate increases targeted at specific non-institutional provider services. Most recently, DHS increased reimbursement rates for certain outpatient mental health and substance abuse services, effective January 1, 2018. In total, the Department estimated that total payments for the affected services would increase by approximately 28% as the result of these changes. Funding for this increase had not been included in the 2017-19 budget; the Department made the decision to increase reimbursement rates for outpatient mental health and substance abuse services to address provider shortages, using base funding for MA benefits.

5. Because of the delay between when services are provided and when claims are submitted, and the additional time needed to see clear trends in the utilization of services, it is still too early to determine what impact, if any, the 2018 reimbursement rate increases had on access to mental health and substance abuse services.

6. Although the Department implemented an increase to mental health and substance abuse reimbursement rates in 2018, these increases did not apply to evaluation and management procedure codes commonly used by psychiatrists for office visits. Instead, the increases applied primarily to individual and group psychotherapy and substance abuse counseling procedure codes.

7. The bill would increase funding for MA benefits for the purpose of reimbursement rate increases, but does not contain statutory or nonstatutory provisions directing the Department as to which services should be affected, how much to increase rates, or even whether to increase reimbursement rates. However, the lack of bill language relating to a provider reimbursement rate increase is not unusual for such increases enacted as part of budget bills. Typically, supporting documents submitted with Governor's bill, or the Legislative Fiscal Bureau summary of the final budget act indicates the intended purpose for increased funding.

8. The Governor's Budget in Brief indicates that the additional funding is intended for "physicians and medical clinics that provide mental health, behavioral health and psychiatric services."

9. Although the budget documents specify that the target of reimbursement rate increases would be physicians providing behavioral health services, the Department of Administration indicates that the intent of the funding was to provide funding for mental health services and physician or clinic services, including potentially physician services that are unrelated to behavioral health. In implementing reimbursement rate increases, DHS indicates that increases would be targeted to physician services for which a shortage of available providers creates access problems for MA enrollees.

10. Federal law requires state Medicaid programs to ensure that payments to providers "are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

11. In 2015, the federal Centers for Medicare and Medicaid Services (CMS) published new regulations requiring state Medicaid programs to regularly monitor and report on access to medical services by beneficiaries who receive those services on a fee-for-service basis. These rules were intended to address concerns that, for various reasons, some Medicaid beneficiaries find it difficult to make medical appointments. One reason for this difficulty is that Medicaid programs may pay providers at a level that is too low for them to agree to accept Medicaid patients.

12. In response to the federal requirement, DHS prepared a report in 2016 on access to MA providers in Wisconsin. The report examines access in six broad categories: primary care, dental, physician specialty, behavioral health, obstetrics, and home health services. For each of these areas, the Department evaluated MA access using various measures, including the percent of providers enrolled in MA and the level of MA participation by enrolled providers.

13. The Department's access report findings relating to the primary care and behavioral health categories are most relevant to the Governor's proposed funding increase for provider reimbursement rates. For these core areas, DHS concludes that provider enrollment and participation in Medicaid is fairly high for primary care physicians, and psychiatrists. Among licensed physicians in the state 85% are enrolled as providers in MA and 72% of those enrolled are considered "active" in the program, meaning that they serve at least 26 MA patients. Among licensed psychiatrists, 81% are enrolled as providers in the program and 73% are active in the program. The report notes, however, that the Department faced some data limitations that may make it difficult to draw reliable conclusions on these measures alone. For instance, the data on primary care provider participation was collected during a period in which federal funding was made available to significantly increase Medicaid reimbursement for primary care services. This may have temporarily increased participation during the study period in a way that is not reflective of ongoing participation.

14. The Department also acknowledged comments of some stakeholders that the minimum threshold for the "active" participation measure -- 26 or more MA patients -- would amount to less than 2% of most primary care physician's total patients. For this reason, some physicians could be

considered active participants, but still have a relatively little involvement in the program.

15. Although a high percentage of psychiatrists are enrolled MA providers and are considered to be active in the program, the Department notes that MA enrollees may still have difficulty scheduling an appointment with a psychiatrist because of the overall shortage of psychiatrists in many parts of the state. That is, access to psychiatrists is a problem that extends beyond MA and, therefore, one which may not be possible to address through MA reimbursement rates alone.

16. In contrast to primary care services provided by physicians or psychiatric services, the Department's FFS access report shows that a substantial share of dentists in the state do not participate in MA. Just 37% of licensed dentists in the state are enrolled providers, and 47% are active in the program. The bill would provide reimbursement rate increases for dental services as part of a separate item. For a discussion of this issue, see LFB Paper #365.

17. HMOs that participate in MA are required by contract to have a network of providers that is sufficient to provide medical care for all enrolled members provide medical care to its enrolled members that is as accessible "in terms of timeliness, amount, duration, and scope" as those services are to FFS MA beneficiaries in the same region. HMOs are required, furthermore, to have written standards for access and must meet certain benchmarks for timeliness of and maximum travel distance to appointments.

18. HMOs must determine whether the reimbursement rates paid to contracted providers are sufficient to meet the contract access guidelines. In some cases, an HMO may decide that it is necessary to pay providers a higher rate than the FFS reimbursement rate. For some services, the Department makes adjustments to the monthly capitation rates paid to the HMOs in recognition that they pay their network providers rates that exceed the FFS rates.

19. The amount of funding provided by the bill for reimbursement rate increases is not tied to any apparent funding benchmarks. Furthermore, because neither the bill nor the administration's supporting documents are clear as to which specific services would be targeted, it is difficult to determine what the effect of the proposed increases would be. Nevertheless, a case can be made that some level of funding for reimbursement rate increases is needed, given that most payments have not been increased since 2008.

20. The administration estimates that the funding in the bill would allow for a rate increase for the targeted services of approximately 8.6% if the increases were applied uniformly to the broad physician/clinic and behavioral health service categories. However, the Department would have discretion to apply different percentage increases to procedure codes within these categories. For this reason, the actual percentage increase for the affected services cannot be known and so is not a meaningful metric for the proposed funding level.

21. Nevertheless, if the Committee agrees that funding for reimbursement rate increases for non-institutional services is warranted, it could provide this amount or a different amount after weighing the merits of this purpose against other funding priorities. The following tables show several alternative funding levels -- including an alternative with no increase -- in comparison with the bill.

The first table shows the change to base by year, while the second shows the same alternatives by the change to bill and to base on a biennial basis.

Reimbursement Rate Funding Alternatives, Change to Base by Fiscal Year

	2019-20			2020-21		
Alternative	GPR	FED	Total	GPR	FED	Total
Governor	$8,732,800	$13,739,100	$22,471,900	$18,217,800	$28,424,700	$46,642,500
A2	15,000,000	23,599,100	38,599,100	30,000,000	46,808,100	76,808,100
A3	10,000,000	15,732,800	25,732,800	20,000,000	31,205,400	51,205,400
A4	5,000,000	7,866,400	12,866,400	10,000,000	15,602,700	25,602,700
A5	0	0	0	0	0	0

Reimbursement Rate Funding Alternatives, Biennial Change to Bill and Base

	Biennial Change to Bill			Biennial Change to Base		
Alternative	GPR	FED	Total	GPR	FED	Total
Governor	$0	$0	$0	$26,950,600	$42,163,800	$69,114,400
A2	18,049,400	28,243,400	46,292,800	45,000,000	70,407,200	115,407,200
A3	3,049,400	4,774,400	7,823,800	30,000,000	46,938,200	76,938,200
A4	-11,950,600	-18,694,700	-30,645,300	15,000,000	23,469,100	38,469,100
A5	-26,950,600	-42,163,800	-69,114,400	0	0	0

22. A case could be made that the best approach for providing increases is to give the Department the discretion in determining which services are most in need of payment increases, based on a consideration of access issues. In this case, the Committee could approve the Governor's proposal, without specific direction (Alternative B1).

23. Alternatively, the Committee may want to include direction in a nonstatutory provision. The direction could range from targeted to more broad-based. Targeted increases can potentially have the greatest impact on access to specific services, while broad-based increases may viewed as more equitable for all providers, but would have less impact on access with the same amount of total funding. Many approaches are possible, but the alternatives under part B offer some possibilities. First, the bill could be amended to require the Department to provide rate increases directed at services with identified access problems (Alternative B2). Second, the Committee could direct the Department to provide broad-based increases at a fixed percentage to physicians/clinics and those mental health services not previously increased in 2018, utilizing the funding provided under this item (Alternative B3). Finally, the Department could be directed to provide increases for all non-institutional services, other than services that are affected by other items, utilizing the funding provided under this item (Alternative B4).

ALTERNATIVES

A. Reimbursement Rate Funding Level

Choose from the biennial funding amounts shown in the following table.

Reimbursement Rate Funding Alternatives, Biennial Change to Bill and Base

	Biennial Change to Bill			Biennial Change to Base		
Alternative	GPR	FED	Total	GPR	FED	Total
Governor	$0	$0	$0	$26,950,600	$42,163,800	$69,114,400
A2	18,049,400	28,243,400	46,292,800	45,000,000	70,407,200	115,407,200
A3	3,049,400	4,774,400	7,823,800	30,000,000	46,938,200	76,938,200
A4	-11,950,600	-18,694,700	-30,645,300	15,000,000	23,469,100	38,469,100
A5	-26,950,600	-42,163,800	-69,114,400	0	0	0

B. Nonstatutory Directive for Funding Increases

1. Approve the Governor's proposal to provide funding increases for mental health, behavioral health, and psychiatric services provided by physicians and medical clinics (DHS discretion with no nonstatutory directive).

2. Require the Department allocate the funding amounts provided under the Alternative A to provide rate increases directed at services with identified access problems.

3. Require the Department allocate the funding amounts provided under the Alternative A to provide rate increases at a fixed percentage to physicians/clinics and those mental health services not previously increased in 2018.

4. Require the Department allocate the funding amounts provided under the Alternative A to provide rate increases at a fixed percentage to non-institutional services other than services affected by other items in the bill or services for which reimbursement rate increases were previously provided in 2018.

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