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M E M O R A N D U M

To: House Committees on Health Care, Human Services and Appropriations; Senate Committees on Health & Welfare and Appropriations

From: Cory Gustafson, Commissioner, Department of Vermont Health Access

CC: Al Gobeille, Secretary, Agency of Human Services
Melissa Bailey, Commissioner, Department of Mental Health
Aaron French, Chief Clinical Officer, Department of Vermont Health Access

Date: February 1, 2017

Re: Act 172, Sec. E.307 – Group Psychotherapy; Medicaid Coverage and Utilization

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This memorandum is in response to the legislature's request in Act 172 of 2016, Section E.307, that the Department of Vermont Health Access (DVHA) analyze Medicaid coverage, reimbursement, utilization, and access to care for outpatient group psychotherapy.

Act 172, Sec. E.307 reads:

> (a) The Department of Vermont Health Access shall, in consultation with interested parties, analyze utilization trends of individual and group psychotherapy to determine if the reimbursement rates currently in place for group therapy are sufficient to sustain access to cost-effective and appropriate psychotherapy services to all Medicaid enrollees eligible to receive services.

Methodology of rate setting for 90853 group psychotherapy rate

Beginning in July 2015, DVHA amended the reimbursement methodology for the group psychotherapy rate (CPT code: 90853). DVHA was required to make this change for the following reasons:

1. Compliance with National Correct Coding Standards.

- Per the National Correct Coding Initiative, the CPT code definition of group psychotherapy has a unit concept of "1 session."
- Prior to the change, DVHA was using a unit concept of "per 15 minutes."
- Vermont Medicaid was not complying with the correct unit definition.

Effective 7/1/15, Medicaid allows 1 session per day for group psychotherapy codes.

2. Align with resource based relative value system (RBRVS) payment methodology.

- Medicaid State Plan requires that reimbursement of professional services such as group therapy follow RBRVS.
- RBRVS is the same underlying system used by Medicare and many other payers. It uniformly sets rates for nearly all medical services covered by Vermont Medicaid. The American Medical Association explains that "RBRVS is based on the principle that payments for physician services should vary with the resource costs for providing those services and is intended to improve and stabilize the payment system while providing physicians an avenue to continuously improve it," (https://www.ama-assn.org/rbrvs-overview, 2017).
- Vermont determined that Medicaid reimbursement for group therapy was two times higher than the rate calculated under RBRVS, meaning that Medicaid was paying for more than the relative resource cost of providing group therapy compared to its payment for other professional services.

To align with RBRVS, Medicaid updated the rate in two steps to allow for a phased in approach:

1. Effective 7/1/15 the rate for 1 session = $41.00
2. Effective 1/1/2016 the rate was updated to current RBRVS methodology = $20.50

Prior to any changes made to the definition of "session" and the rate change for group psychotherapy (90853), DVHA assessed several states to understand how each state was reimbursing for this same service. Vermont Medicaid's new rate is similar to other state Medicaid agencies. See chart below.

State Medicaid	Current Rate for 90853
NJ Medicaid	$8.00
RI Medicaid	$14.40
WV Medicaid	$18.65
VT Medicaid	**$20.50 (effective 1/1/2016)**
ME Medicaid	$20.88
NH Medicaid	$21.12
NY Medicaid	$21.26
MD Medicaid	$23.93
DE Medicaid	$24.06
CT Medicaid	$34.13

Monitoring Access to Care

DVHA has monitored the effect of this rate change in an effort ensure access to care for those seeking mental health services. DVHA monitors access to care in a number of ways, including the tracking of utilization data, provider enrollments and disenrollments, documentation of provider and consumer complaints, stakeholder meetings, and by conducting surveys.

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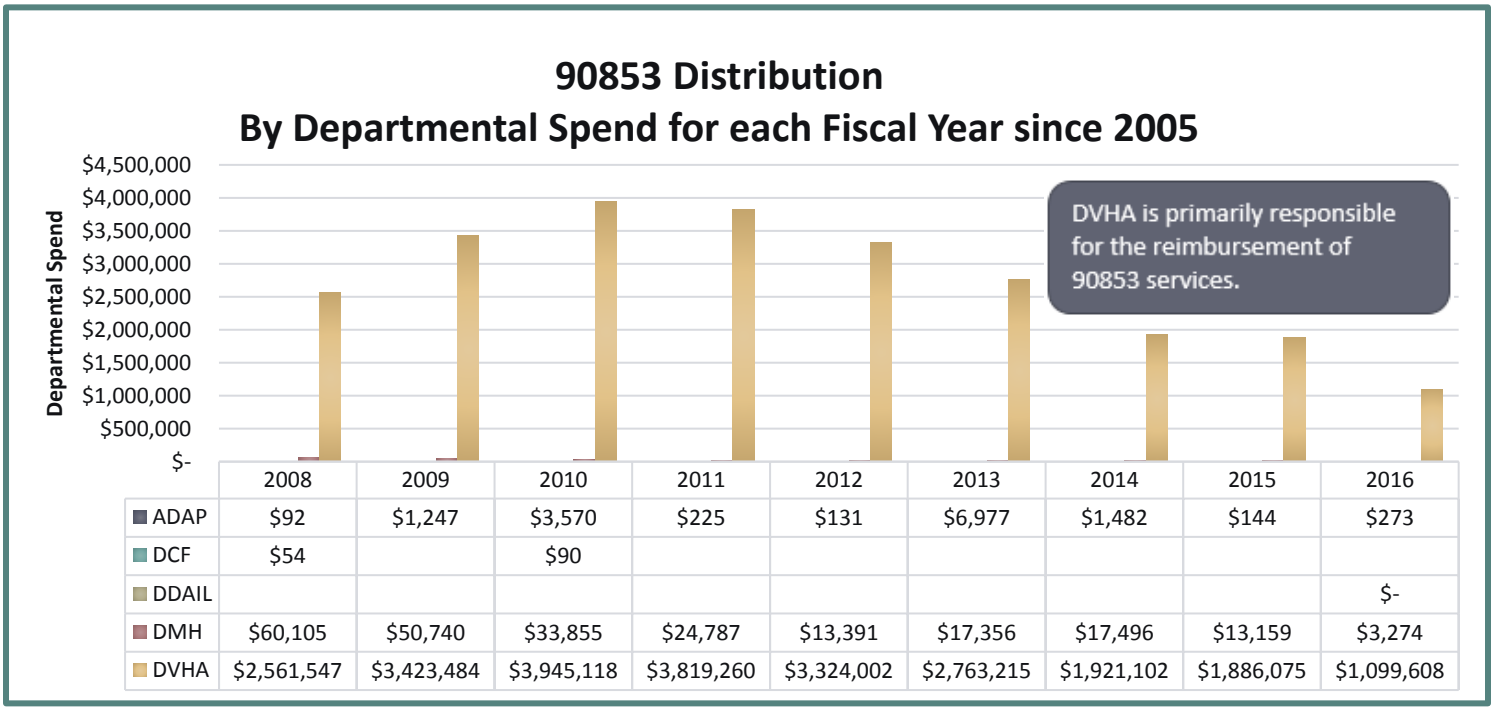
DVHA collaborated with the Department of Mental Health (DMH) to evaluate the impact of changes to reimbursement for group therapy on access to these services and ability of providers to provide the service at the new rate.

In July 2016, DVHA and DMH met with Vermont Care Partners (VCP) and its members. The intent of this meeting was to further discuss the impacts that the 90853 definition and rate changes have had on the system of care. It was agreed upon that DVHA and DMH should survey all Designated Agencies (DAs) and independent providers. Additionally, DVHA and DMH reached out to Vermont Mental Health Counselors Association (VTMHCA) to explain the approach and to elicit input from independent Medicaid-enrolled providers. A survey consisting of six questions was developed by DVHA, DMH and VCP, including questions specific to reimbursement and cost of service provision. The survey was sent to providers, and received a high response rate from all DAs and independent providers. Survey questions and summaries of the responses are available in Appendix A below.

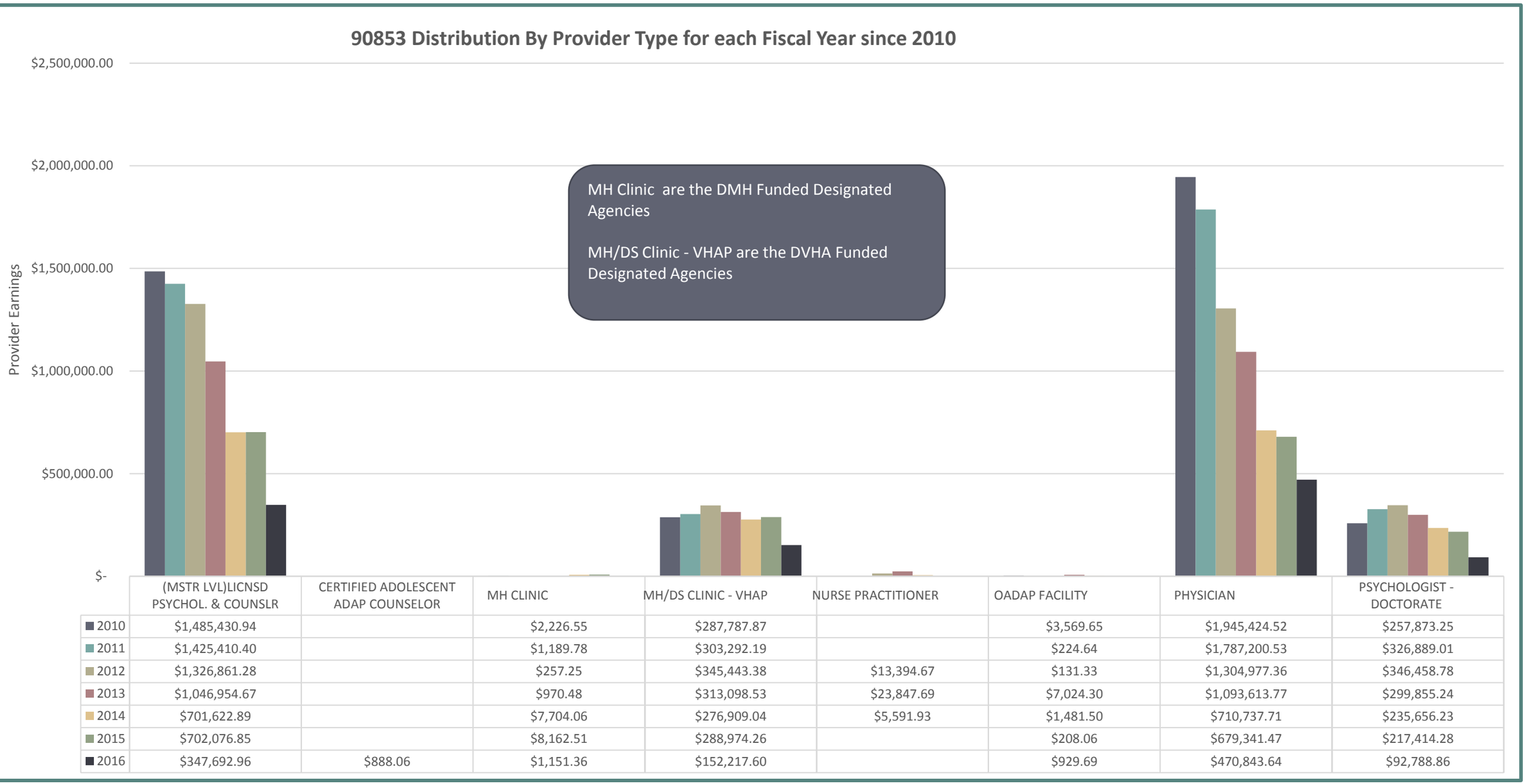
In addition to conducting a survey, DVHA tracked the utilization of group therapy in order to understand the trend over years and assess the impact of these rate changes. The two charts below show that group therapy expenditures have been declining every year since state fiscal year (SFY) 2011. While these phased in rate changes did begin July of 2015, between SFY 2010 and SFY 2014 expenditures had already decreased by roughly 50% due to declining utilization. This trend continued through 2016. Table 2 shows the decrease in expenditures by provider type.

Table 1.



	2008	2009	2010	2011	2012	2013	2014	2015	2016
ADAP	$92	$1,247	$3,570	$225	$131	$6,977	$1,482	$144	$273
DCF	$54		$90						
DDAIL									$-
DMH	$60,105	$50,740	$33,855	$24,787	$13,391	$17,356	$17,496	$13,159	$3,274
DVHA	$2,561,547	$3,423,484	$3,945,118	$3,819,260	$3,324,002	$2,763,215	$1,921,102	$1,886,075	$1,099,608

Table 2.



	(MSTR LVL)LICNSD PSYCHOL. & COUNSLR	CERTIFIED ADOLESCENT ADAP COUNSELOR	MH CLINIC	MH/DS CLINIC - VHAP	NURSE PRACTITIONER	OADAP FACILITY	PHYSICIAN	PSYCHOLOGIST - DOCTORATE
2010	$1,485,430.94		$2,226.55	$287,787.87		$3,569.65	$1,945,424.52	$257,873.25
2011	$1,425,410.40		$1,189.78	$303,292.19		$224.64	$1,787,200.53	$326,889.01
2012	$1,326,861.28		$257.25	$345,443.38	$13,394.67	$131.33	$1,304,977.36	$346,458.78
2013	$1,046,954.67		$970.48	$313,098.53	$23,847.69	$7,024.30	$1,093,613.77	$299,855.24
2014	$701,622.89		$7,704.06	$276,909.04	$5,591.93	$1,481.50	$710,737.71	$235,656.23
2015	$702,076.85		$8,162.51	$288,974.26		$208.06	$679,341.47	$217,414.28
2016	$347,692.96	$888.06	$1,151.36	$152,217.60		$929.69	$470,843.64	$92,788.86

As utilization for group therapy has been decreasing since 2011, utilization of individual psychotherapy has been on the rise. Some of the increased utilization of individual psychotherapy can be attributed to the decline in group therapy, but the rate of growth cannot be explained solely by the decline in group. Other factors contributing to this trend could include increased Medicaid enrollment, growing awareness of the treatment modality, and more frequent assessments of need for individual therapy. Table 3 below compares expenditures on psychotherapy services from SFY 2013 to SFY 2016.

Table 3.

	2013	2014	2015	2016
EVALUATION	$674,961	$1,700,084	$1,600,223	$1,602,621
FAMILY PSYCHOTHERAPY	$2,211,712	$1,614,049	$1,594,843	$1,618,974
GROUP PSYCHOTHERAPY	$2,787,549	$1,940,080	$1,899,379	$1,103,155
INDIVIDUAL PSYCHOTHERAPY	$4,572,645	$13,604,360	$16,965,592	$20,329,396

DVHA plans to continue to monitor overall access to mental health services to ensure that Medicaid beneficiaries receive medically necessary services in a timely manner and Medicaid providers receive payments that are consistent with efficiency, economy, and quality of care.

Based on the comparison of regional rates for group psychotherapy, federal compliance requirements for correct coding and rate methodology development, along with the changing utilization trends of group psychotherapy, DVHA believes that the current rates are sufficient to sustain access to cost-effective and appropriate psychotherapy services.

Appendix A—July 2016 Provider Survey Questions and Response Summaries

1. Have the rate reductions had an impact on client access to group therapy services within your practice? Please do not include any work outside of private practice, as DAs are being surveyed separately.

Overwhelmingly, all providers stated yes to this question. However, DVHA is not aware that any DAs have stopped providing these services. DAs have created waitlists. No providers (DAs or Independents) have un-enrolled from Medicaid due to this change in reimbursement; however, we would not expect providers to un-enroll in Medicaid since they provide other services covered by Medicaid.

2. Have the rate reductions had any other impact (e.g. loss of practice revenue)?

Most providers replied yes to this question. Providers stated that they have experienced: decreased revenue, less staff to deliver services, and longer wait times for patients.

3. If yes to questions #1 or #2 above, how have you mitigated those impacts or what steps have you taken to address them**?**

Many DA providers have shifted to single facilitation (1 clinician per group), not growing programs despite need, and some have shifted from group therapy to individual therapy or are sustaining existing programs through revenue gains in other parts of the agency. Additionally, some providers stated that they are less motivated to offer groups due to the low reimbursement by Vermont Medicaid. Most DAs bill for these services under the DMH Medicaid cap until they reach the annual maximum and then bill directly through DVHA at the new rate. One DA stated that they introduced a self-pay model for one program. Please note that this is not allowed for Medicaid beneficiaries.

4. Have you seen an increased demand for either group or individual services in this time frame?

Most providers responded that they have not seen an increase in demand, but rather an increase in wait times for patients to get into group sessions. One provider stated that he/she saw an increase in crisis services and individual therapy sessions. Providers have reduced staff, therefore there are fewer providers to provide the service.

5. Please use the attached template to make an estimate of the cost of providing group therapy services in your program.

Providers were asked to complete a spreadsheet of costs for group therapy programs versus revenues per event to determine what rate is needed to sustain and provide a group therapy program. The responses from providers had a wide variation between DAs, ranging from $48.11 per session to as high as $96.00 per session, with an average group size of 5 patients. The variation in costs reported by providers may be due to items such as administrative costs and staffing rate variations.

6. Additional comments, suggestions or observations.

All responses are captured above.