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A REVIEW OF MINNESOTA MEDICAID REIMBURSEMENT RATES: 2004-2014, Impacts on Mental Health Providers

Prepared in partnership with
NAMI Minnesota

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# Table of Contents

Executive Summary ............................................................................................................. 1

Introduction ......................................................................................................................... 2

Background ......................................................................................................................... 2
  Definitions ....................................................................................................................... 2
  Medicare ......................................................................................................................... 4
  Medicaid ......................................................................................................................... 5

History .................................................................................................................................. 7

Findings ............................................................................................................................... 9
  Sample Practice Analysis ............................................................................................... 9
  Rate Impacts on Workforce .......................................................................................... 11

Recommendations: ............................................................................................................ 13

Appendix One: CPT Code Changes from 2012 to 2013 ......................................................... 1

Appendix Two: Rate Change Analyses ............................................................................. 2
Executive Summary
In response to comments from mental health providers that Medical Assistance rates are insufficient to provide quality care, and have been falling behind over time, the author and facilitators of this study have reviewed the impact of the last 10 years of rate changes in Minnesota for mental health services under Medicaid. While highly variable according to individual practice characteristics, our analysis of actual practices shows that Minnesota’s previously passed Medical Assistance rate increases for mental health providers have not been sufficient to keep pace with medical inflation, and have contributed to a shortage of mental health providers in the workforce. In particular, while the 23.7% rate increase delivered in 2007 was a step in the right direction, the value of the increase has eroded significantly over time. The rate increase does not apply to all providers providing important mental health access, and many clinics receive even lower rates than indicated if using master’s level providers. Therefore, we recommend that the Minnesota Legislature take the following steps to improve mental health reimbursement under Medical Assistance, and address the significant financial challenges threatening access to care for our state’s residents:

- Extend the 23.7% increase to all mental health providers, and not tie increases to status as Community Mental Health Center or CTSS certification
- Implement a disproportionate-share type payment to Medicaid mental health providers
- Eliminate Master’s level cutback
- Bring rates at least in line with Medicare—most are well below for non Community Mental Health Centers (noting that Medicare rates for mental health are often insufficient as well)
- Make PMAP data publicly available; audit PMAP payments to ensure rates are correctly paid, and ensure current fee schedules are implemented immediately
- Implement additional HCPCS codes to cover currently non-billable services
Introduction
This report was sponsored by the University of Minnesota’s Center for Urban and Regional Affairs’ Nelson Program, in partnership with NAMI Minnesota, and further assistance from community mental health representatives, in particular, Mary Regan, Executive Director of the Minnesota Council of Child Caring Agencies.

The goal of this report is to assess the impact of Medicaid (in Minnesota, “Medical Assistance”) fee schedule changes on Minnesota’s non-facility mental health providers, and recommend priorities for change in the current legislative session. The Medicaid fee schedule in each state sets the amount paid to providers for providing services to Medicaid enrollees. While controlled to a large extent by State Legislatures, the fee schedule can also be impacted by forces outside of the legislature’s control, including federal waiver requirements, and other healthcare reimbursement changes at large, such as changes to the Resource Based Relative Value Unit (“RBRVU”) schedule.

Therefore, to properly assess the current reimbursement climate for mental health providers under Medicaid, this report will examine both the discrete financial impact of the changes, as well as the environment in which such changes are occurring. To do this, we will first provide background information on healthcare billing in general, and under Medicaid in Minnesota. Second, we will provide an overview of the history of Medicaid funding for general healthcare and mental healthcare services in Minnesota. Then, the adequacy of mental health care funding through the Medicaid fee schedule will be assessed with a two-pronged test, (i) an analysis of the resulting change in Medicaid revenues for various practices over the last 10 years, and (ii) a review of the impact of reimbursement on the mental health workforce. Finally, after considering our findings, concrete action steps will be proposed.

Background
Medicaid rate setting is related to medical reimbursement practices at large, and especially to Medicare. Therefore, to understand Medicaid rate setting, we will start with a definition of two terms important to the reimbursement process. Then, we will review the reimbursement process under Medicare and Medicaid.

DEFINITIONS
Before moving to a review of Medicare and Medicaid reimbursement methodology, it is important to understand the meaning and origin of two terms involved in the process, CPT codes and RVUs, which are described below:

Relative Value Units (“RVUs”)
RVUs are a measurement of the intensity of the resources required to perform a service in three areas: (i) physician work, (ii) practice expense, and (iii) malpractice. A service’s physician work RVU component is determined by the time required for a physician to perform the service, as well as the perceived difficulty of the services (for example, as surgeons undergo more years of training, generally their time is valued more than those physicians that have less intensive training, such as primary care). The practice expense RVU component represents the tangible resources required to provide the service (e.g. radiology
services have a high practice expense value, as the equipment to perform radiology is expensive, whereas there are few practice expenses associated with many primary care visits). The final component, malpractice expense, encompasses the relative malpractice cost associated with a given procedure (for example, as obstetric physicians are subject to a high number of malpractice claims relative to other physician specialties, a delivery is a relatively high malpractice expense service). Finally, all three of these components are adjusted for differences in cost in the geographic region in which the service is provided (according to the Geographic Practice Cost Index, or GPCI).

While seemingly a neutral quantitative measurement, the RVU is not without biases. It is set by the American Medical Association’s Specialty Society Relative Value Scale Update Committee (“RUC”), which is comprised mostly of specialist physicians. Therefore, as specialty (as opposed to primary care) physicians are setting the schedule, the RVU schedule has historically favored procedures (such as surgeries, interventional radiology, etc.) over cognitive services (such as a face to face encounter with a non-interventional radiologist, or a visit with a primary care physician, where a problem is discussed but no tangible physical intervention is performed). RVUs are assigned to Current Procedural Terminology (“CPT”) codes—and CPT codes are a way in which physicians describe their services.

CPT Codes
The CPT code set is a list maintained by the American Medical Association. It very specifically describes the medical services provided (as opposed to a diagnosis). An example of a CPT code is as follows (the codes and their descriptions are copy written by the AMA):

99201: OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS: A PROBLEM FOCUSED HISTORY; A PROBLEM FOCUSED EXAMINATION; STRAIGHTFORWARD MEDICAL DECISION MAKING. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT’S AND/OR FAMILY’S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE SELF LIMITED OR MINOR. TYPICALLY, 10 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY.
The CPT code list changes from time to time, in order to encompass new procedures or ways of doing things in a given specialty. The mental health section of CPT codes was changed in 2013. Prior to this, mental health codes were last changed in 1998. An example of this reorganization of the CPT code schedule for psychiatry is appended to this report, in Appendix 1.

MEDICARE
Medicare is the most frequently used rate schedule in the United States\(^1\). Due to Medicare’s universal application, it functions as a benchmark rate in healthcare in terms of measurement and contracting. For measurement purposes, it can be useful to compare a program’s spending over time relative to Medicare, to determine whether it has grown more or less quickly, and reimburses more or less favorably. The comparison to Medicare may also be made directly in the contracting process, and it is not uncommon for a payor to set rates as a percentage of Medicare (i.e. a private payor may agree to pay 110% of Medicare’s rates for a given service). Historically, healthcare providers have tried to operate based on average payment rates slightly above Medicare rates, as generally Medicaid paid less than Medicare, and commercial payors paid more. However, reimbursement rates have declined across the board and Medicaid enrollment has increased, making the reimbursement climate increasingly unfavorable for providers.

The link between Medicare and Medicaid comes from the federal government’s role in funding each. The federal government, through its waiver process of approving states’ Medicaid programs, is beginning to cap expenditures for particular services in certain states at Medicare levels of reimbursement. While this is still somewhat unusual, and most services are not required to be paid at Medicare rates, as federal healthcare spending is playing an expanding role in Medicaid programs through the Affordable Care Act’s expansion, the potential for Medicare payment levels to be imposed upon other programs increases. Mental health access advocates in other states have reported being told by CMS that they must cut rates that are in excess of Medicare.

Under Medicare, for each service provided, physicians are paid a given amount (\(\$X\)) per Relative Value Unit (or “RVU”): \(\$X \times \text{RVU}\). In 2014, \(\$X\) was $35.83, and the payment rate is updated periodically by the federal government. As noted in the definitions section, RVUs are assigned to CPT codes. Therefore, while the Medicare fee schedule is dependent both on RVU changes, and reimbursement rate (\(\$X\)) changes, it is also a function of CPT code changes. CPT code changes can affect the RVUs a provider

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\(^1\) While Medicaid covers more enrollees (69m) than Medicare (48m) in 2011, the Medicare rate schedule is more uniform, as it is operated by the federal government, versus the separate state programs. http://kff.org/health-reform/perspective/pulling-it-together-medicare-medicaid-and-the/
generates. Though a provider may be providing the same services year to year, the CPT codes that the provider bills as a result may change. A change in CPT codes means that the resulting RVUs could change, leading to different payment levels. For example, for psychiatry, providers used to generally bill according to units of time (e.g. one code for 30 minutes of psychotherapy, a different code for 60 minutes, etc.) Now, while some services are still billed according to time, others are billed in two parts: one code for the service, and another for time.

The specific impact of the CPT code changes varies by practice, and is taken into account in our analysis. According to studies conducted by the University HealthSystem Consortium and the Association of American Medical Colleges, in conjunction with the Faculty Practice Solutions Center, the impact of the mental health CPT code changes from 2012-2013 was approximately an annual net 2% decrease\(^2\) in RVUs generated by psychology practices; however, the result of changes to the RBRVU schedule to those CPT codes (which were unchanged) from 2013 to 2014 was a net 8% annual increase in Medicare revenues for psychologists and 6% for psychiatrists\(^3\). While these trends are general across a specialty, our analysis later on will show that the impact of fee schedule changes, along with CPT and RBRVU changes, can result in varying outcomes for practices.

In summary, under Medicare, while the reimbursement rate may increase (from $38 to some higher number) if the RVUs associated with the service provided decreases, either due to CPT schedule reorganization or changes in the RVUs as set by the RUC, the overall payment could fall.

MEDICAID
As noted above, Medicare generally pays a fixed amount per unit. Medicaid is not as simple. Our research could not uncover the exact formulas used to arrive at Medicaid reimbursement rates in Minnesota (whereas for Medicare, the formulas are very clear). However, Medicaid rates generally correlate with Medicare rates, and the Minnesota DHS notes in its fee schedules that “Starting in January 2011, many rates for CPT codes (those not starting with “H” or “S”) were recalculated based on the Center for Medicare and Medicaid (CMS) Resource Based Relative Value Scale (RBRVS)”, indicating that the relative payment for each procedure is based on the CMS RBRVS schedule, though the amount per unit may be different. However, the legislative process of raising rates for certain services while there may be no change or cuts in rates for other services, means that while the “base” schedule is likely calculated in the same way that Medicare is ($X per RVU, though for Medicaid, “X” is generally less), the final fee schedule is the result of certain increases or decreases applied to that “base” rate, some of which are uniform, and some of which are not.

Therefore, CPT code reorganization, and RVU disparities contribute to the Medicaid fee schedule in the same way that they do to Medicare’s. Additionally, the way in which the Medicaid fee schedule is set as part of the state budgetary process, leads to several other unique characteristics of the Medicaid fee schedule. Reimbursement for certain services may be mandated by the federal government, affecting state

\(^2\) [https://www.aamc.org/download/323302/data/aamc-uc-fpse2013pfsfinalruleimpactanalysispresentation.pdf]
\(^3\) [https://www.aamc.org/download/364670/data/aamc-uhcfpscmedicarephysicianfeeschedulefinalruleandimpactanal.pdf]
spending: for example all primary care services received increases as part of the Affordable Care Act. States (contingent on federal waiver approval) can also move to change payment rates for select services, like Minnesota’s increase for Children’s Therapeutic and Support Services (“CTSS”) in 2008, described in more detail in the next section. Targeted increases are the result of policy decisions made using similar political processes involved in other legislative action. While these increases are often intended to be a one-time “correction” of a perceived deficiency in the fee schedule, broad cost of living increases applied year to year on top of one-time adjustments perpetuates the rate schedule differences/decisions made in the past, rather than starting fresh in consideration of the current state of affairs. What may start as a single change could have broad repercussions, as due to budget neutrality requirements, some areas may be cut to compensate for increases in others.

The Medicaid fee schedule varies greatly across states, and also varies between specialties and within specialties. One way of measuring the Medicaid fee schedule generosity is to do so relative to Medicare, and examples of differences are noted in the tables below.

- Table 1 illustrates the differences in Medicaid reimbursement levels relative to Medicare between states and specialties. The categories listed are the most discrete available, and while they do not break out mental health reimbursement specifically, the differences in relative payment levels for other services between states, makes it clear that states can determine their own Medicaid spending priorities, and often do so to great effect (for example, OB providers in Wisconsin are paid about a third more than those in Minnesota).

<table>
<thead>
<tr>
<th>Location</th>
<th>All Services</th>
<th>Primary Care</th>
<th>Obstetric Care</th>
<th>Other Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iowa</td>
<td>112%</td>
<td>118%</td>
<td>97%</td>
<td>118%</td>
</tr>
<tr>
<td>Minnesota</td>
<td>106%</td>
<td>123%</td>
<td>77%</td>
<td>104%</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>108%</td>
<td>97%</td>
<td>110%</td>
<td>133%</td>
</tr>
</tbody>
</table>

- As seen above, there are broad differences in relative Medicaid reimbursement with respect to state and specialty. There may also be differences in a state’s Medicaid reimbursement relative to Medicare, within each specialty. Table 2 shows the differences in relative reimbursement levels between selected mental health services in Minnesota for services performed at Community Mental Health Centers:

4 Source: http://kff.org/medicaid/state-indicator/medicaid-fee-index/
It is important to note that higher relative payments do not necessarily indicate a better Medicaid program overall, as the table below does not indicate breadth of services covered, nor does it illustrate the number of persons covered—for example Minnesota does have more generous eligibility guidelines for Medicaid than Wisconsin.
Generally, very similar services do not have different relative reimbursement generosity levels (e.g. individual psychotherapy, regardless of length, all pays about the same relative to Medicare).

**History**

With a basic understanding of the healthcare system’s reimbursement methodology, we can turn to the history of changes in Medicaid mental health reimbursement in Minnesota over the last 10 years. The following is a summary of major rate changes for Medical Assistance in Minnesota during such time, as taken from NAMI Minnesota’s legislative summaries:

- **2006 Session**: Rates for certain mental health professionals increased 23.7% effective July 1, 2007. The increase applied to psychiatrists; advanced practice nurses with a psychiatric specialty; community mental health centers; mental health clinics and centers, and hospital outpatient psychiatric departments designated as essential community providers (nonprofits who serve low-income, uninsured, high risk, etc.), for group skills training when it is provided as part of Children’s Therapeutic Services and Supports (CTSS), psychotherapy, medication management, evaluation and management, diagnostic assessment, explanation of findings, psychological testing, neuropsychological services, direction of behavioral aides and inpatient consultation.

- **2007 Session**: Cost of living increases of 2% per year were given to any provider that was currently awarded an adult or children’s mental health grant, and providers furnishing Rehabilitation Mental Health Services (ARMHS) or Children’s Therapeutic Services and Supports (CTSS). Providers had to pass on 75% of the increased revenue to support staff salaries and benefits. Additionally, in January 2008, rates increased 23.7% for behavioral aide services and certain services provided by CTSS providers and medication education under ARMHS. Certain individual and family skills training provided under CTSS received an additional 2.3% increase. Mental Health providers received a 2% rate increase beginning October 1, 2007 and again July 1, 2008 for adult mental health care grants and Adult Mental Health Rehabilitation Services.

- **2008 and 2009 Sessions**: No change

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5 [http://www.namihelps.org/legislative-update.html](http://www.namihelps.org/legislative-update.html)
• 2010 Session: Beginning 2011, the Commissioner of Human Services established three levels of reimbursement rates for providers conducting mental health diagnostic assessments based on the complexity of the individual.

• 2011 Session: The state, instead of counties, began to set rates for Intensive Residential Treatment Services (IRTS), Assertive Community Treatment (ACT) and Crisis Residential beds. As IRTS and ACT teams serve people from more than one county, the goal of the change was to simplify the contracting process, providing the state as a single source to establish rates, instead of multiple county contacts. In setting the rates, the department looked at the actual costs of the program (for staff, etc.). Up to 5% of the rates were set aside for meeting performance criteria.

• 2012 Session: No changes

• 2013 Session: Mental health providers, along with physicians, PT, OT, and speech therapists had their reimbursement under Medical Assistance increased by 5% starting September 1, 2014. Dental rates increased 5% starting January 1, 2014. Providers of waivered services, nursing and home health, and personal care assistance received a rate increase of 1% beginning April 14, 2014. A 1.67% rate cut scheduled to take effect on July 1, 2013 was eliminated as well.

• 2014 Session: No Changes

As shown in the summaries above, legislative rate changes over the last ten years were often applied to a particular subset of services or providers, and there were somewhat large increases given in some years, with no increases given in others. This means that the impact of the last 10 years of rate increases is not constant (e.g. 5% per year). While significant changes may be observed from one year to the next, the result is a much smaller increase when averaged over time. Additionally, the actual codes used for services (and the corresponding RVUs) may have changed significantly as a result of the CPT code reorganization from 2012 to 2013. Therefore, while rates before and after the CPT code change may be somewhat consistent, it is important to remember that the way in which providers were able to bill for their services changed. On an aggregate basis, the effect of all of these changes is analyzed in the following section. For illustrative purposes, an example of the effect of these rate changes on a single service year to year is shown in Table 3 below. Table 3 shows the change in payment rates (and the CPT code used) for Individual Psychotherapy 45-50 min, non interactive complexity, performed by a psychologist at a CMHC:

<table>
<thead>
<tr>
<th>CPT Code for Individual Therapy</th>
<th>Rate 01/01/04</th>
<th>Rate 1/1/06</th>
<th>Rate 10/1/07</th>
<th>Rate 1/1/08</th>
<th>Rate 1/1/09</th>
<th>Rate 1/1/10</th>
<th>Rate 1/1/11</th>
<th>Rate 1/1/12</th>
<th>Rate 1/1/13</th>
<th>Rate 1/1/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>90806</td>
<td>$75.60</td>
<td>$75.60</td>
<td>$93.52</td>
<td>$93.52</td>
<td>$93.52</td>
<td>$93.52</td>
<td>$95.49</td>
<td>$94.44</td>
<td></td>
<td></td>
</tr>
<tr>
<td>90834</td>
<td>$92.83</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$94.03</td>
</tr>
</tbody>
</table>

This table is intended to illustrate the changes in a given service year to year, as a result of the legislative changes summarized above, as well as outside (i.e. not a result of state legislature action) changes such as the CPT code change. It is not intended to represent the status of mental health reimbursement at large. Note that for the given service, the 23.7% increase can be observed in the change in the rate from 2006 to 2007. The change in the CPT code schedule can be seen in the change in the code used from 2012, to 2013. It is important to note that there is not a 1:1 relationship between 90806 and 90834, a provider may not bill 90834 every time they used 90806, as additional codes may be used for complex patients.
Additionally, while 90806 was for services for 45-50 minutes, 90834, according to new CPT time measurement guidelines, could be used for services 38-52 minutes in length.

**Findings**

**SAMPLE PRACTICE ANALYSIS**

To assess the effect of rate changes over the last 10 years, we tested the impact of fee schedule changes on three actual practices (the “Example Practices”). This is done because the impact of the fee schedule is not uniform, and varies for each practice as a result of the services provided, the type of practice (e.g. Community Mental Health Center or not), and the providers used (e.g. master’s level, doctoral, etc.). The impact of fee schedule changes varies depending on the services provided by an organization, because only certain services were targeted for increases, and outside factors such as CPT code reorganization impacted the fee schedule. Therefore, a provider providing a large proportion of services eligible for the increase, stands to gain much more than someone who only spends a small portion of their time providing such services. The practice type also has an impact, as certain rates are only increased for Community Mental Health Centers6 (“CMHC’s”), and lower rates are applicable to other practice types. For this reason, we tested the rate schedule under both CMHC and non-CMHC rate schedules. Additionally, the provider type also has an effect. At CMHC’s, master’s level providers earn the same amount under the fee schedule as doctoral level providers. At non-CMHC’s, master’s level providers earn 80% of the fee schedule amount. For the purposes of our analysis, we assumed that all services were provided by doctoral level providers, as it does not affect the rate of fee schedule changes, it simply impacts the level of fee schedule changes (as one is always 80% of the other if cut) and is a more generous way of measuring the rate climate.

Note that these practices are not intended to be a representative sample, they are merely the organizations that responded to our data request. However, they do represent a full spectrum of mental health services in the community. Additionally, our sample practice estimates were not an attempt to replicate an “average” practice. The meaning of the illustrations is to show actual examples of rate changes.

The results of the analysis are in Appendix Two. From this analysis—our findings are as follows:

- A one-time 23.7% increase given seven years ago is worth much less today (as arithmetic would also show).
- As the 23.7% increase was only for select services, for many practices that provide a variety of services, this translates to much less than a 23.7% increase in overall reimbursement

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6 CMHC’s are organizations certified by the state, that provide a breadth of quality mental health services to community members

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• The situation for Master’s level providers at non-CMHC’s is even worse, as reimbursement is at 80% of the fee schedule.

• The practice with the highest demonstrated increase from 2004-2014 was one that provided a high number of CTSS services (Example #3). For CTSS services, all organization types are eligible for a higher rate, however non-CMHC’s do still have a master’s level cutback. Therefore as visible in Example #3, the status of the organization as a CMHC did not have a substantial impact on revenues, as we assumed all services were provided by doctoral level providers.

• Aside from the CTSS-heavy provider (Example Practice #3), there were substantial decreases in revenues for providers under the non-CMHC schedule, versus using the CMHC schedule (where the 23.7% increases can apply).

• The Example Practices’ rate increases from 2004-2014 were in most cases, well below the rate of medical cost increases during the same time period, as calculated using the Bureau of Labor Statistics’ Medical Cost CPI7. To compare the Example Practices to medical cost increases over the last ten years, we calculated the cumulative increase in rates/prices for each from 2004-2014, and then noted the percentage change of rates/prices in 2014 vs. 2004. Graphs comparing the example practices to medical inflation under the non-CMHC rate schedule, as well as under the more generous CMHC rate schedule, are below.

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7 Note that there are many measures of medical inflation. The CPI is a consumer level measurement, but encompasses a wide variety of medical services:
http://data.bls.gov/timeseries/CUUR0000SAM?output_view=pct_12mths
From this analysis, particularly of Example Practices #1 and #2, we can see that there are many instances in which providers are not receiving sufficient rate increases to keep up with medical inflation. Even Example Practice #3, which is somewhat of a special case as a primarily CTSS provider\(^8\), is barely keeping pace with medical inflation. This rate environment has numerous impacts, and one that we will examine here is the impact on the state’s mental health workforce, in the next section.

**RATE IMPACTS ON WORKFORCE**

While there are many reasons for a shortage of mental health care providers outside of financial compensation\(^9\), low financial compensation for mental health providers is an important factor.

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\(^8\) CTSS services received a 23.7% increase in all settings, meaning that Example Practice #3 is illustrative of a “best case” in the current mental health funding structure, and is not indicative of the general experience of mental health providers

\(^9\) The state of Minnesota’s mental health workforce is currently being studied by the Mental Health Workforce Steering Committee, which is planning on publishing a final report in 2015.
The following is a summary of the financial conditions of the mental health workforce today. Note that where psychiatry-only data is used, it is because of a lack of robust general mental health provider data. However, trends that apply to psychiatrists are indicative of trends for other mental health providers.10

1. Practice revenue for mental health providers is down, and salary increases are well below market:
   (this data is for psychiatrist-led practices11, but includes practices that employ other mental health providers, such as nurse practitioners, social workers, etc.):
   - Revenue per Psychiatry FTE
     - 2008: $441,500
     - 2013: $328,800 (down 25%)
   - Practice operational costs
     - 2008-2013: roughly unchanged
   - Total Compensation for Psychiatrists
     - 2008: $209,900
     - 2013: $244,900 (16% increase)
     - For comparison: Even family practice, which is often targeted for payment increases due to perceived poor compensation and high demand for services, experienced an increase in compensation of 28% in the same timeframe. This indicates that psychiatry is truly at the bottom of the industry in wage increases.

2. Many services provided by mental health professionals are not reimbursed:
   - For example, for children’s providers, major service requirements that are not reimbursed include: milieu, basic needs and social services assistance, service coordination with educators, other providers and parents, administrative paperwork.

3. There is a shortage, nationally and state-wide, of mental health providers at all levels:
   - National M.D. Data13
     - Retirement on the horizon: 70% of psychiatrists are 50 or older, compared to 43% of physicians overall
     - Fewer national medical school graduates are selecting psychiatry, and more than 30% of active psychiatrists are international medical school graduates (posing retention concerns)

10 While the relationship between psychiatry and other mental health providers is not 1:1, the data is generally correlated, as psychiatrists often work in practices with, or employ other mental health providers, meaning that the practice conditions experienced by psychiatrists are applicable to many mental health providers in general.
11 According to AMGA cost survey (national data limited to M.D.’s)
12 Hennepin County CMHC CTSS and Day Treatment Cost Finding Project, January 14, 2009
13 Source: Merritt Hawkins 2012 Review of Physician Recruiting Incentives
Bureau of Health Professions projects 19% increase in demand for general psychiatry services between 1995 and 2020
100% increase in demand for child psychiatric services projected in same timeframe

- Minnesota Data
  - 9 of 11 of MN’s geographic regions designated as “Mental Health Professional Shortage” areas
    - Situation is worsening: 3 of the regions received this designation as recently as 2012
    - Only the metro area and Southeastern Minnesota (because of the Mayo Clinic in Rochester) are not designated shortage areas
  - Recruiting psychiatrists and certified nurse specialists/nurse providers are the most challenging assignments in terms of length of time: 55% of responders to a survey of over 500 mental health stakeholders reported more than one year to recruit a psychiatrist and 42% reported the same time frame to recruit a clinical nurse specialist.
  - There are 5.2 psychiatrists for every 100,000 people in rural Minnesota. In the U.S. that ratio is 11 psychiatrists per 100,000
  - CMHC’s report that the wait time for a psychiatric appointment for a new client in MN is around 3 months, for child and adolescents that wait is even longer

It is clear that the rate of mental health reimbursement increases under Medical Assistance in Minnesota has not been sufficient. Increases have not kept up with the rate of medical inflation, and this has resulted in negative financial impacts that contribute to a worsening shortage of mental health professionals nationally and locally.

**Recommendations:**

The above analysis makes it clear that while the impact of the Medical Assistance fee schedule changes varies among practices, and is a result, in part, of certain factors outside of the state legislature’s control, mental health providers are not receiving sufficient rate increases to keep pace with medical inflation, much less address the historical undervaluing of mental health services in general. This failure to adequately fund the mental health workforce can be seen in declining mental health practice revenues, and a declining supply of mental health providers, in the face of increasing demand, leading to an ever worsening shortage. Informed by the analysis, we have made several recommendations to improve the financial condition of the mental health workforce in Minnesota, and ensure continued access to quality care for Medical Assistance recipients, and the community at large:

- Extend 23.7% increase to all mental health providers, and not tie increases to status as Community Mental Health Centers or CTSS certification

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14 Mental Health Workforce Steering Committee Draft Report (2014)
As shown in our analysis, providers receive significantly less reimbursement if not a Community Mental Health Center, and are receiving increases well below the rate of medical inflation. The definition of CMHC is very narrow, and with the evidence of mental health provider shortages above, it is important to support the ability of all providers to furnish access to care.

- Implement a disproportionate-share type payment to Medicaid mental health providers
  - This is one way of accomplishing the goal of providing fair reimbursement to all providers that serve a large proportion of Medicaid patients. It is currently used for reimbursing large hospitals, meaning that it should be a viable option for smaller practices as well.

- Eliminate Master’s level cutback
  - The analysis demonstrates rates of increase under Medicaid well below medical inflation, but assumes the highest level of reimbursement. Master’s level providers at non-CMHC’s receive only 80% of the fee schedule amount—meaning that the situation is even more dire for those practices using Master’s level providers to expand to provide needed access.

- Bring rates at least in line with Medicare—most are well below for non CMHC’s (noting that Medicare rates for mental health are often insufficient as well)
  - While even Medicare level rates may not be enough, for non CMHC’s, most mental health payment rates are well below Medicare level payment rates. Medicare is considered a survival level rate amongst many providers, and reimbursing below this results in significant financial challenges.

- Make PMAP data publicly available; audit PMAP payments to ensure rates are correctly paid, and ensure current fee schedules are implemented immediately
  - While not directly addressed in our analysis above, many providers we met with expressed concern regarding payment from PMAPS. We were unable to analyze these claims due to a lack of data, and it is important for providers to be able to advocate for themselves and receive fair treatment from healthcare payors that receive large amounts of state funding.

- Implement additional HCPCS codes to cover currently non-billable services
  - In the analysis, in Appendix Two, codes starting with H are an example of these HCPCS codes, which are implemented to provide a code and reimbursement for a service that isn’t covered by existing CPT codes. As seen in the appendix, these codes cover very valuable services, and as shown above, many mental health care providers still provide many services for which they can’t obtain payment. Particularly with mental health, these activities (such as securing shelter, or food, or clothing) are needed to facilitate the provision of medical services, and are often required by patients most in need. Payment for these services through the continued creating of HCPCS codes to cover them, ensures that they can continue
## Appendix One: CPT Code Changes from 2012 to 2013

### Comparison of 2012 Mental Health CPT Codes to 2013 CPT Codes

<table>
<thead>
<tr>
<th>Service</th>
<th>2012 CPT Code(s)</th>
<th>2013 Status</th>
<th>Service</th>
<th>2013 CPT Code(s)</th>
<th>Report with Interactive Complexity (+90785)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic interview examination</td>
<td>90801</td>
<td>Deleted</td>
<td>Diagnostic evaluation (no medical)</td>
<td>90791</td>
<td>When appropriate</td>
</tr>
<tr>
<td>Interactive diagnostic interview examination</td>
<td>90802</td>
<td>Deleted</td>
<td>Diagnostic evaluation (no medical)</td>
<td>90791</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Psychotherapy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual psychotherapy 20-30 min</td>
<td>90804, 90816</td>
<td>Deleted</td>
<td>Psychotherapy 30 (16-37*) min</td>
<td>90832</td>
<td>When appropriate</td>
</tr>
<tr>
<td>45-50 min</td>
<td>90806, 90818</td>
<td>Deleted</td>
<td>45 (38-52*) min</td>
<td>90834</td>
<td></td>
</tr>
<tr>
<td>75-80 min</td>
<td>90808, 90821</td>
<td>Deleted</td>
<td>60 (53+*) min</td>
<td>90837</td>
<td></td>
</tr>
<tr>
<td>Interactive individual psychotherapy 20-30 min</td>
<td>90810, 90823</td>
<td>Deleted</td>
<td>30 (16-37*) min</td>
<td>90832</td>
<td>Yes</td>
</tr>
<tr>
<td>45-50 min</td>
<td>90812, 90826</td>
<td>Deleted</td>
<td>45 (38-52*) min</td>
<td>90834</td>
<td></td>
</tr>
<tr>
<td>75-80 min</td>
<td>90814, 90828</td>
<td>Deleted</td>
<td>60 (53+*) min</td>
<td>90837</td>
<td></td>
</tr>
<tr>
<td><strong>Psychotherapy with E/M (there is no one-to-one correspondence)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual psychotherapy with E/M, 20-30 min</td>
<td>90805, 90817</td>
<td>Deleted</td>
<td>E/M plus psychotherapy add-on</td>
<td></td>
<td>When appropriate</td>
</tr>
<tr>
<td>45-50 min</td>
<td>90807, 90819</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>75-80 min</td>
<td>90809, 90822</td>
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<tr>
<td>Interactive individual psychotherapy with E/M 20-30 min</td>
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<tr>
<td>45-50 min</td>
<td>90813, 90827</td>
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</tr>
<tr>
<td>75-80 min</td>
<td>90815, 90829</td>
<td>Deleted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Other Psychotherapy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(None)</td>
<td></td>
<td></td>
<td>Psychotherapy for crisis</td>
<td>90839, +90840</td>
<td>No</td>
</tr>
<tr>
<td>Family psychotherapy</td>
<td>90846, 90847, 90849</td>
<td>Retained</td>
<td>Family psychotherapy</td>
<td>90846, 90847, 90849</td>
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<tr>
<td>Group psychotherapy</td>
<td>90853</td>
<td>Retained</td>
<td>Group psychotherapy</td>
<td>90853</td>
<td>When appropriate</td>
</tr>
<tr>
<td>Interactive group psychotherapy</td>
<td>90857</td>
<td>Deleted</td>
<td>Group psychotherapy</td>
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<td>Yes</td>
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<tr>
<td><strong>Other Psychiatric Services</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacologic management</td>
<td>90862</td>
<td>Deleted</td>
<td>E/M</td>
<td>E/M code</td>
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</table>

*Per CPT Time Rule*
## Appendix Two: Rate Change Analyses

### Sample Provider #1

<table>
<thead>
<tr>
<th>Description/Rate Package</th>
<th>2014 (Referral)</th>
<th>2014 (Reported)</th>
<th>2015 (Reported)</th>
<th>2016 (Reported)</th>
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</thead>
<tbody>
<tr>
<td>Providing Service</td>
<td>Total</td>
<td>Total</td>
<td>Total</td>
<td>Total</td>
</tr>
<tr>
<td>Psychotherapy 0-4 months</td>
<td>3-206,524</td>
<td>317,500</td>
<td>317,500</td>
<td>317,500</td>
</tr>
<tr>
<td>Psychotherapy 5-11 months</td>
<td>5-979,500</td>
<td>979,500</td>
<td>979,500</td>
<td>979,500</td>
</tr>
<tr>
<td>Psychotherapy 12-23 months</td>
<td>12-12,500</td>
<td>12,500</td>
<td>12,500</td>
<td>12,500</td>
</tr>
<tr>
<td>Psychotherapy 24-36 months</td>
<td>24-113,500</td>
<td>113,500</td>
<td>113,500</td>
<td>113,500</td>
</tr>
<tr>
<td>Total</td>
<td>275,827</td>
<td>292,500</td>
<td>292,500</td>
<td>292,500</td>
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</table>

### Sample Provider #2

<table>
<thead>
<tr>
<th>Description/Rate Package</th>
<th>2014 (Referral)</th>
<th>2014 (Reported)</th>
<th>2015 (Reported)</th>
<th>2016 (Reported)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing Service</td>
<td>Total</td>
<td>Total</td>
<td>Total</td>
<td>Total</td>
</tr>
<tr>
<td>Psychotherapy 0-4 months</td>
<td>3-206,524</td>
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<td>317,500</td>
<td>317,500</td>
</tr>
<tr>
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<td>5-979,500</td>
<td>979,500</td>
<td>979,500</td>
<td>979,500</td>
</tr>
<tr>
<td>Psychotherapy 12-23 months</td>
<td>12-12,500</td>
<td>12,500</td>
<td>12,500</td>
<td>12,500</td>
</tr>
<tr>
<td>Psychotherapy 24-36 months</td>
<td>24-113,500</td>
<td>113,500</td>
<td>113,500</td>
<td>113,500</td>
</tr>
<tr>
<td>Total</td>
<td>275,827</td>
<td>292,500</td>
<td>292,500</td>
<td>292,500</td>
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</table>

### Sample Provider #3

<table>
<thead>
<tr>
<th>Description/Rate Package</th>
<th>2014 (Referral)</th>
<th>2014 (Reported)</th>
<th>2015 (Reported)</th>
<th>2016 (Reported)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing Service</td>
<td>Total</td>
<td>Total</td>
<td>Total</td>
<td>Total</td>
</tr>
<tr>
<td>Psychotherapy 0-4 months</td>
<td>3-206,524</td>
<td>317,500</td>
<td>317,500</td>
<td>317,500</td>
</tr>
<tr>
<td>Psychotherapy 5-11 months</td>
<td>5-979,500</td>
<td>979,500</td>
<td>979,500</td>
<td>979,500</td>
</tr>
<tr>
<td>Psychotherapy 12-23 months</td>
<td>12-12,500</td>
<td>12,500</td>
<td>12,500</td>
<td>12,500</td>
</tr>
<tr>
<td>Psychotherapy 24-36 months</td>
<td>24-113,500</td>
<td>113,500</td>
<td>113,500</td>
<td>113,500</td>
</tr>
<tr>
<td>Total</td>
<td>275,827</td>
<td>292,500</td>
<td>292,500</td>
<td>292,500</td>
</tr>
</tbody>
</table>
Even though with code changes (in Appendix One) it is challenging to precisely translate services provided in one year to a different year's schedule, this can be done with a high degree of accuracy as we have provider data from before and after the coding switch, so it is possible to see general coding trends year to year. The actual codes used, when two codes are possible, are shown in bold. Certain physician physical health services, or certain county-lump sump services, that are not under the mental health rate schedule, were excluded for analytical consistency and simplicity. In general, the result of all of these work steps was to result in a margin of error that may overstate the level of increase, rather than understate it.

<table>
<thead>
<tr>
<th>Example Provider</th>
<th>2014 (Reported)</th>
<th>2008 (Mapped)</th>
<th>2004 (Mapped)</th>
<th>2007 (Mapped)</th>
<th>2004 (Shipped)</th>
<th>2007 (Shipped)</th>
<th>2004 (Mapped)</th>
<th>2007 (Mapped)</th>
<th>2004 (Shipped)</th>
<th>2007 (Shipped)</th>
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<tbody>
<tr>
<td></td>
<td>Code</td>
<td>Rate</td>
<td>Code</td>
<td>Rate</td>
<td>Code</td>
<td>Rate</td>
<td>Code</td>
<td>Rate</td>
<td>Code</td>
<td>Rate</td>
</tr>
<tr>
<td>96101 Psychological testing</td>
<td>$71.47</td>
<td>$6,933</td>
<td>96101</td>
<td>$84.52</td>
<td>$8,198</td>
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<td>$88.40</td>
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<tr>
<td>96101 psychological testing</td>
<td>$84.52</td>
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<td>96101</td>
<td>$84.52</td>
<td>$8,198</td>
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<td>$84.52</td>
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<td>96101 Psychological testing</td>
<td>$84.52</td>
<td>$8,198</td>
<td>96101</td>
<td>$84.52</td>
<td>$8,198</td>
<td>96101</td>
<td>$84.52</td>
<td>$8,198</td>
<td>96101</td>
<td>$88.40</td>
</tr>
</tbody>
</table>

Notes: Even though with code changes (in Appendix One) it is challenging to precisely translate services provided in one year to a different year’s schedule, this can be done with a high degree of accuracy as we have provider data from before and after the coding switch, so it is possible to see general coding trends year to year. The actual codes used, when two codes are possible, are shown in bold. Certain physician physical health services, or certain county-lump sump services, that are not under the mental health rate schedule, were excluded for analytical consistency and simplicity. In general, the result of all of these work steps was to result in a margin of error that may overstate the level of increase, rather than understate it.