Bureau of Legislative Research

Arkansas Health Care Reform Task Force

Broad Analysis of Behavioral Health for Multiple Claims on a Day
TSG Update Report
January 20, 2016

Executive Summary

- The Stephen Group assessed 4 theories of possible Behavioral Health cost issues. Extending the small sample we reported in December, today's report is based on looking at *all* the claims for certain codes for *all* BH beneficiaries in calendar 2014
- Findings: 23% of claims are multiples in a day, $40MM in the year.
- Additional observations:
  - Medicaid lacks outcome metrics suitable for assessing the *value* beneficiaries achieve through these added services
  - Services at the school decline only 23% in the summer. Are providers over-treating in the school year, or under-treating in the summer? What is the cost to Education of keeping schools open for BH service?
  - While beneficiaries have Master Treatment Plans, it appears no one is managing various providers' services to achieve beneficiary outcomes
- Based on these findings, TSG makes 3 immediate courses of action

Do Behavioral Health Claims Include Multiple Claims on a Given Day?

TSG reported in December its 4 theories about "potential" overuse:

1. Beneficiaries in Rehabilitative Day Service (H2017) also have charges for other treatment on the same day. Two issues: (1) H2017 already includes some care, and (2) a beneficiary might not benefit from more than the hours of Day Service
2. Students receiving at-school treatment (H2015 (intervention with paraprofessional) with place of service code 03) might be claiming for other care.
3. Students not receiving H2015 care might be receiving more care than is reasonable given that they are in school 6 hours a day already. This is a concern only during the school year
4. During summer, students might be receiving more treatment than during the school year.

Behavior Health Charge Codes

Code	Description	2014 Amount
H2015	**Intervention, Mental Health Paraprofessional**	**87,168,612**
H0004	**Behavioral Health Counseling & Therapy, Per 15 Minutes**	**78,111,549**
92507	Individual Speech Therapy	65,348,908
90853	**Group Outpatient – Group Psychotherapy**	**51,079,618**
99213	Established Patient Office or Other Outpatient Visit, Typically 15 Minutes	33,739,081
99214	Established Patient Office or Other Outpatient, Visit Typically 25 Minutes	29,204,758
H2017	**Rehabilitative Day Service**	**21,058,742**
90887	Explanation of Psychiatric Examination Results	15,805,678
90885	Psychiatric Examination of Records	14,139,721
90847	**Family Medical Psychotherapy With The Patient Present**	**13,860,035**
	Other	55,169,807
	Total*	464,686,509

Today, we will consider 5 codes (bold) that relate directly to the 4 theories. Together, they account for 54% of total Behavioral Health claims dollars

* TSG worked with Accounting and the Program to find the link between the Program's list of services and Accounting's record of the BH cost. There is an issue that neither group knows just how MMIS combines services codes and sub-codes into Accounting's "State Categories of Service" for BH. However, the codes in question total less than $10MM dollars and full reconciliation would have no effect on the current analysis. Thus, TSG was able to complete the analysis successfully without full reconciliation.

Hypothesis 1: Rehabilitative Day and Other Services on Same Day

- Look at 3 codes for related services:
  - Rehabilitative Day Service (H2017)
  - Intervention by Mental Health Professional (H2015)
  - Individual Psychotherapy (counseling) (H0004)
- While providers might claim for other codes on a day, the services are not as closely related as these. For example, speech therapy or administration of drugs is not directly related to rehabilitative day service and would not represent multiple claims in our analysis
- The assessment looks for the number of claims of all 3 types for a given beneficiary on a given day
- Note that a more granular hypothesis could account for claims at the modifier level—beyond the scope of the current analysis

Description of Claim Codes

	Description	Limits	Expected Outcome
H0004 Counseling and therapy	Face-to-face treatment provided by a licensed mental health professional on an individual basis	Maximum of 4 15-minute units per day, 48 per year	Reduce or alleviate identified symptoms, maintain or improve level of functioning, or prevent deterioration
H2015 Intervention	Face-to-face medically necessary treatment activities…specific therapeutic interventions as prescribed on the master treatment plan	Maximum of 8 units per day, prior authorization, scheduled or unscheduled	Improve the beneficiary's progress toward specific goal(s) and outcomes
H2017 Day Service	Face-to-face interventions providing a preplanned and structured group program for identified beneficiaries that improve emotional and behavioral symptoms	Maximum of 16 units per day, 80 per week	Enhance a youth's functioning in the home, school, and community with the least amount of ongoing professional intervention

Method

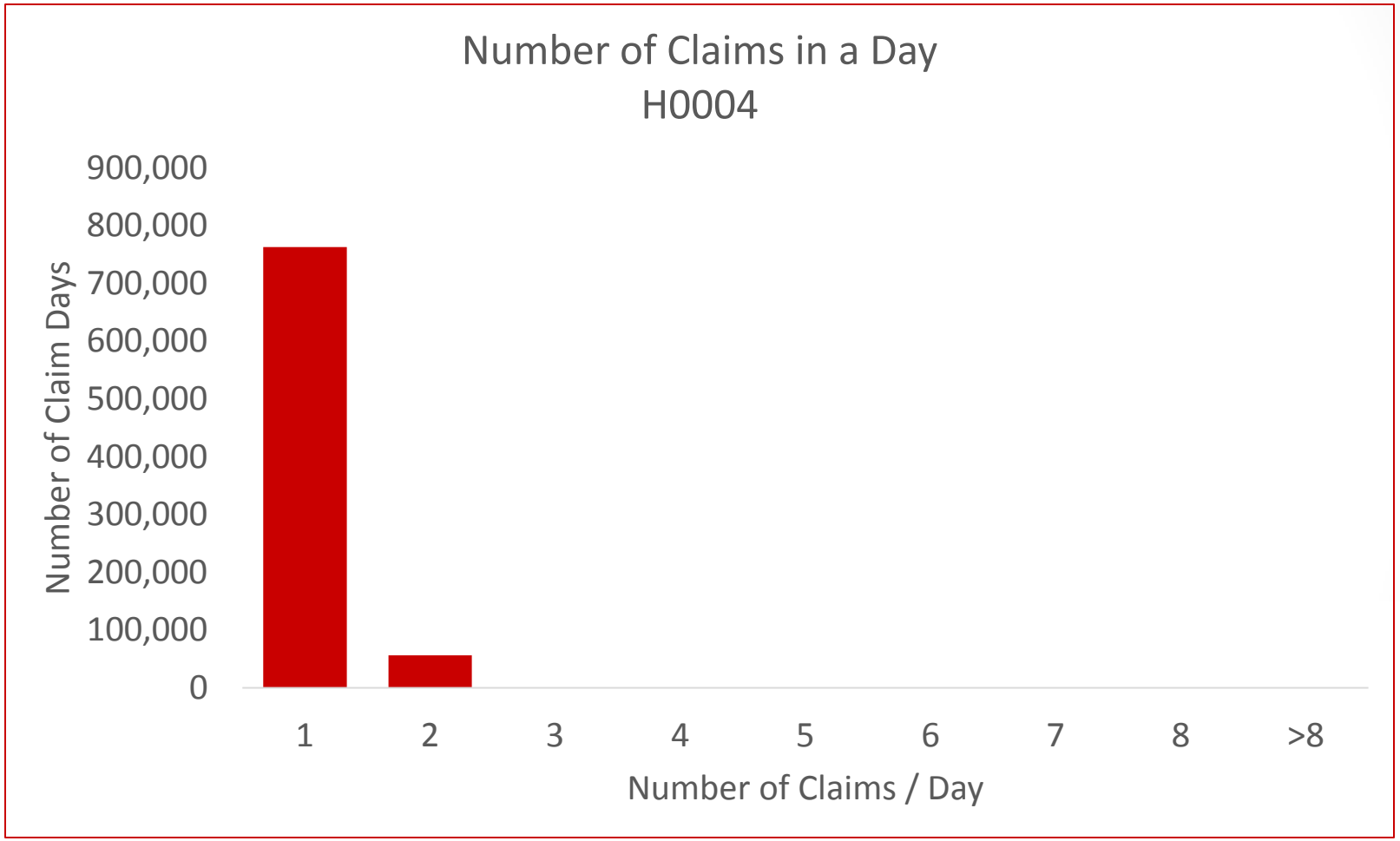
- Create a table of beneficiaries (columns) and days of the year (rows). In each cell report the number of claims: 1, 2, 3, etc. on that day
  - That is a table with 365 columns and 74,000 beneficiaries who received at least one service of these codes during the year. This is 27 million potential claim days in all
  - Most beneficiaries do not have claims most days. Of the 27 million possible claim days, 23 million (85%) have no claims
- Look at each day, count the number of claims on days for which there are more than 1 claim for any of the 3 codes
- Look also at the amounts for claims per day

We looked first at multiple claims on a day for the *same* code
We then looked for multiple claims for *any* of the 3 codes

The Beneficiaries and Claims

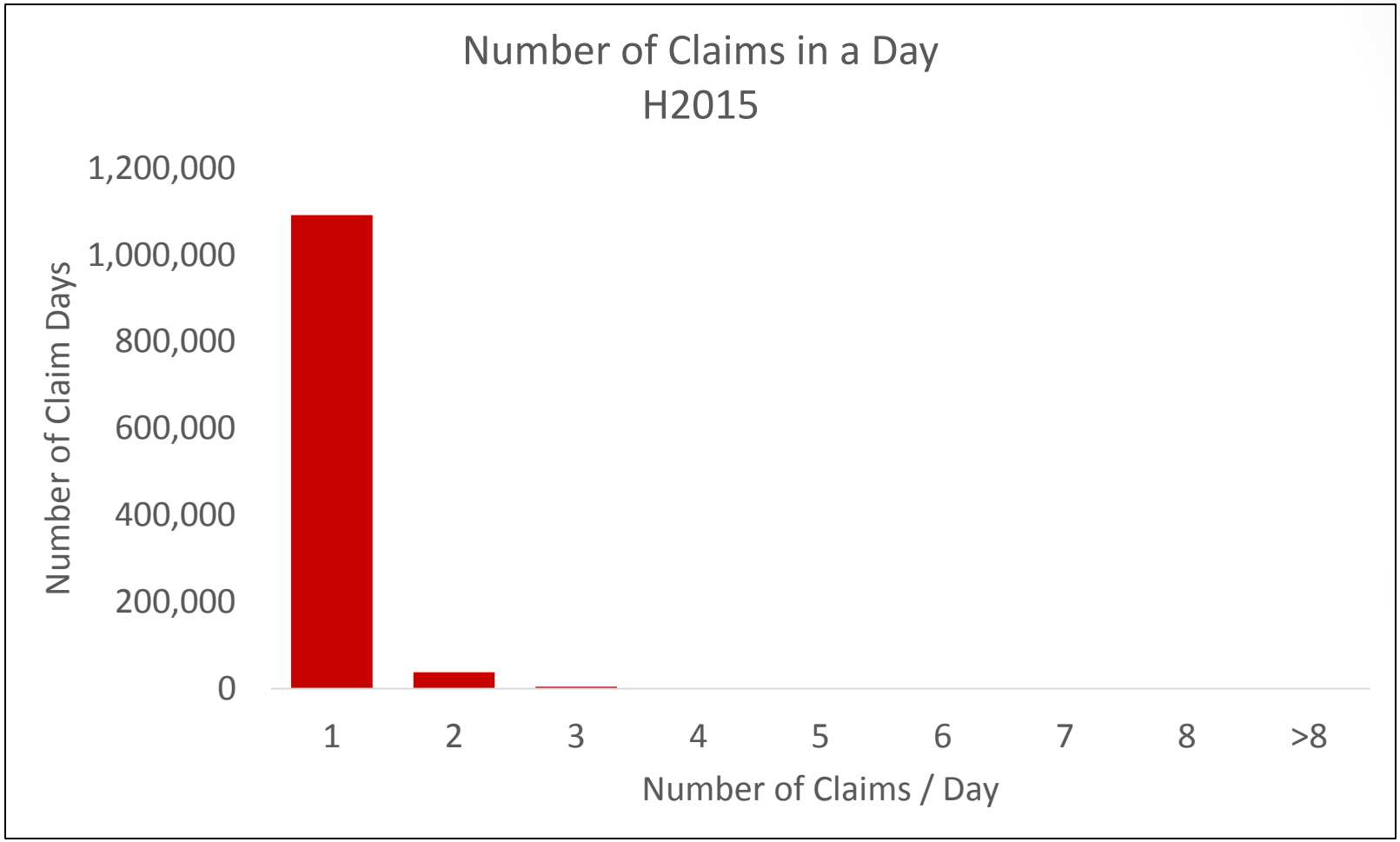
- 46,000 beneficiaries claimed some level of service for one or more of these 3 codes during the year
- Thus, there could be 17MM days of claims (46K*365). However, there are only 2.3MM days on which claims were made. Thus, on average providers are claiming services for each beneficiary about once every two weeks (2.3MM/17MM)
- In total, providers claimed 2.4MM claims for these three codes. This amounts to $186MM of the $464MM in BH claims

Multiple Same-Day Claims Are Made for Code H0004* – 7% of the Time



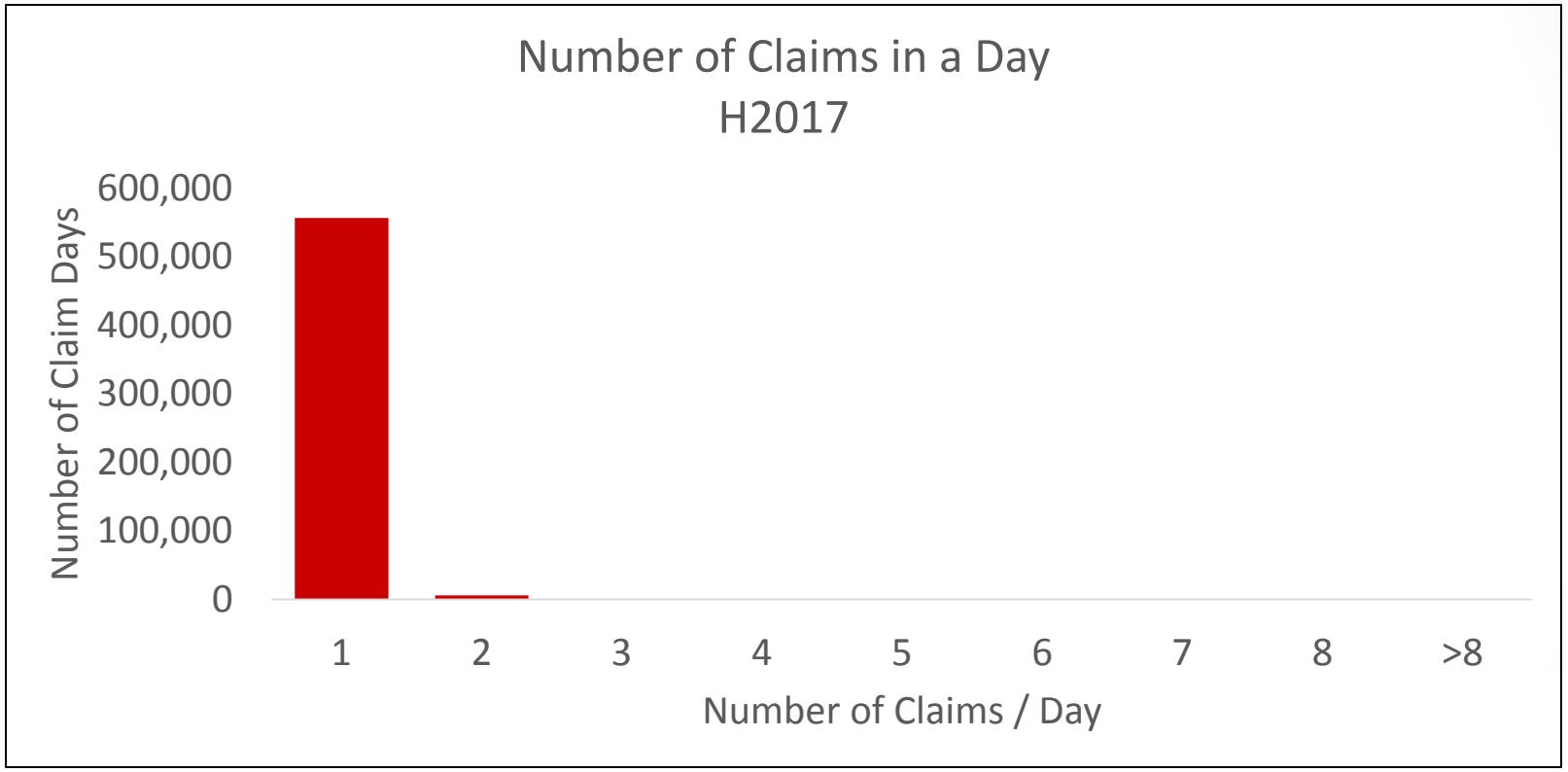
* H0004 = Behavioral Health Counseling & Therapy

Multiple Same-Day Claims Are Made for H2015* – 3.7% of the Time



* H20-15= Intervention, Mental Health Professional

Multiple Same-Day Claims Are Made for H2017* – 1.0% of the Time



* H2017=Rehabilitative Day Service

Potential from Reducing Multiple Claims of the *Same* Code in a Day

Code	Multiple Claims	Average Claim*	Opportunity
H0004 (Coun/Ther)	56,268	$97.72	$5.4MM
H2015 (Interv)	47,813	$76.55	$3.4MM
H2017 (Day)	5,746	$39.70	$0.2MM

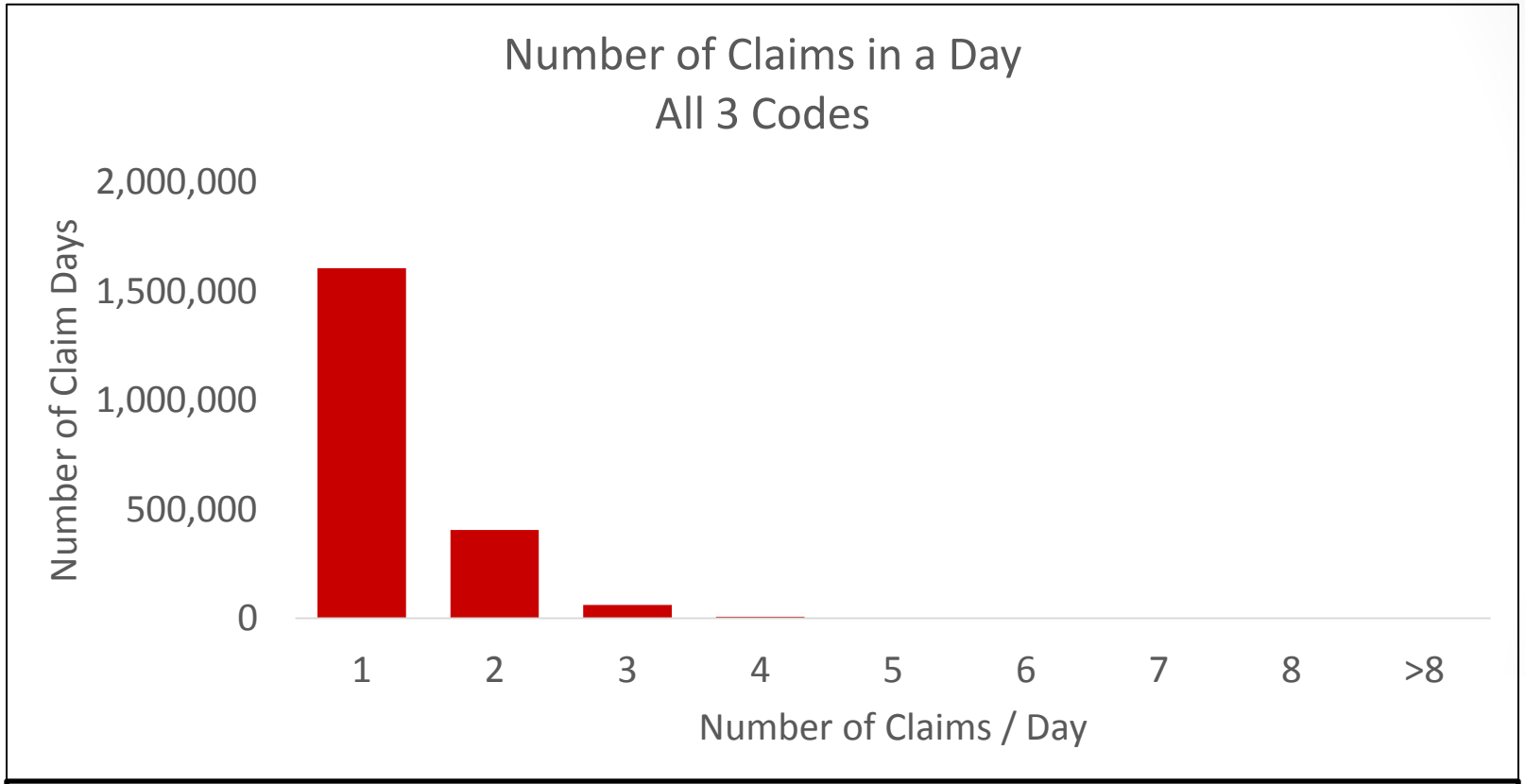
Why is this? What are the valid clinical reasons that a beneficiary requires the same clinical intervention more than once per day?
$9 MM opportunity is already accounted for in the overall potential from reducing multiple claims of all 3 codes

H2015 Intervention, Mental Health Paraprofessional

H0004 Behavioral Health Counseling & Therapy, Per 15 Minutes

H2017 Rehabilitative Day Service

Moreover, on 23% of Days Beneficiaries Claim Multiples of the 3 Codes



Looking across all three codes, multiple claims are frequent. When there is a claim, 19.5% of time there is a second claim that day; 2.9% a third claim

Theory 1: Substantiated

- Beneficiaries claiming for Rehabilitative Day Service (H2017), Intervention, Mental Health Professional (H2015) and Behavioral Health Counseling and Therapy (H0004) have second or third claims on the same day 23% of the time. Does the beneficiary truly benefit from more than one service?
- In addition, Beneficiaries have claims for THE SAME service 7%, 3% and 1% of the time (respectively). Are the same services a second time in the day beneficial or is this a possible coding issue?
- TSG does not suggest that there is never a clinical reason for multiple claims on a day. Sometimes 2 or 3 of these services might improve outcomes. However, the State lacks evidence that they do.

Cost of Multiple Services of a Day (H0004, H2015 & H2017)

- 547,000 claims are “multiple in a day”. For example, if there are three claims in a day for the above codes this would represent two “multiple in a day” claims.
- We cannot tell which of the 3 services is the most effective clinically. So, we use the weighted average claim amount for the day of the 3 claim types: $75*
- The potential from completely eliminating multiple claims of these three codes is $40MM

Agenda

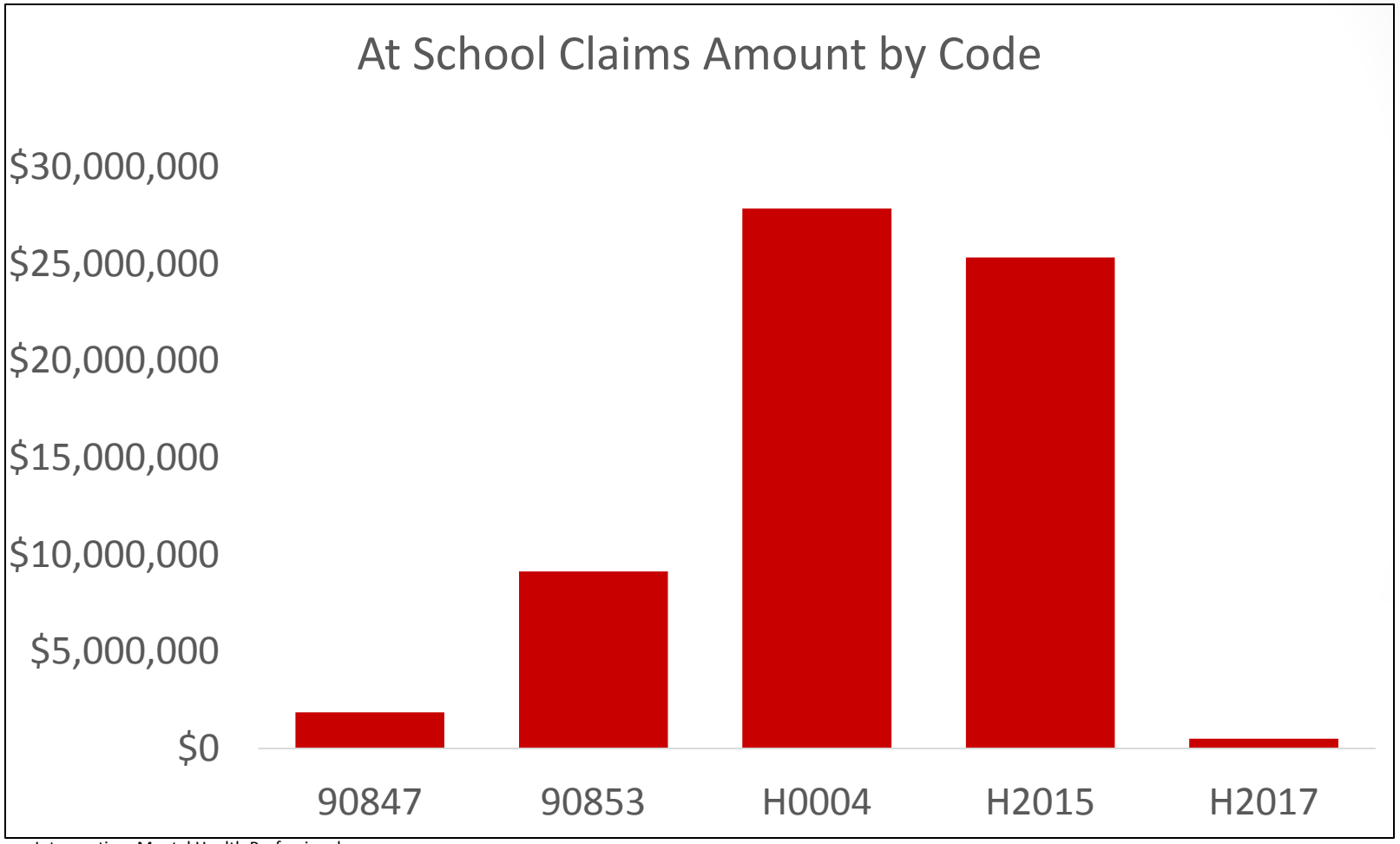
TSG developed 4 theories about potential overuse:

1. Beneficiaries in Rehabilitative Day Service (H2017) also have charges for other treatment on the same day. Two issues: (1) H2017 already includes some care, and (2) a beneficiary might not benefit from more than the hours of Day Service
2. Students receiving at-school treatment (H2015 with place of service code 03) might be claiming for other care. Similar questions as with Theory 1: how much care is reasonable?
3. Students not receiving H2015 care might be receiving more care than is reasonable given that they are in school 6 hours a day already. This is a concern only during the school year
4. During summer, students might be receiving more treatment than during the school year.

Description of Two Additional Claim Codes

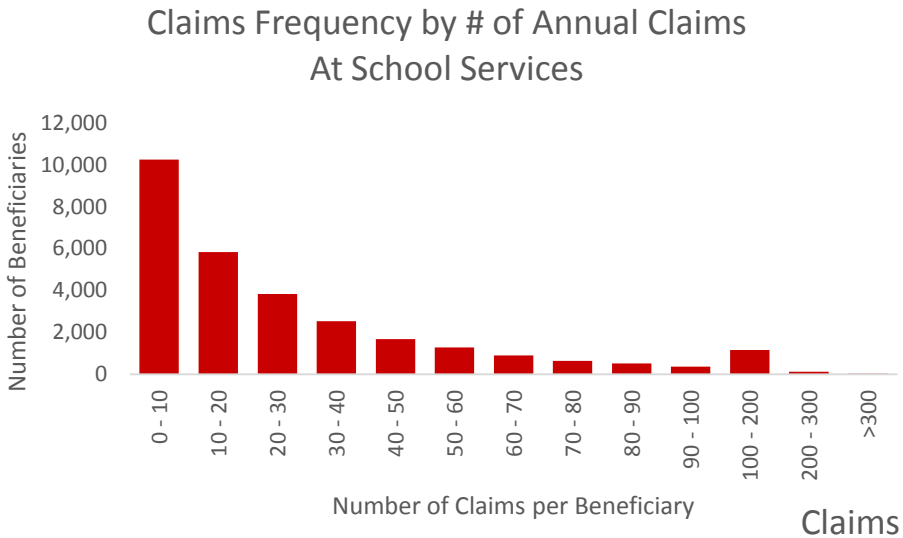
	Description	Limits	Expected Outcome
90847	Face-to-face treatment provided to more than one member of a **family** simultaneously	Maximum of 6 per day	Identify and address marital/family dynamics
90853	Face-to-face interventions provided to a **group** of beneficiaries on a regularly scheduled basis to improve behavioral or cognitive problems which either cause or exacerbate mental illness	Maximum of 6 per day	Beneficiary's response to the Intervention, Mental Health Professional

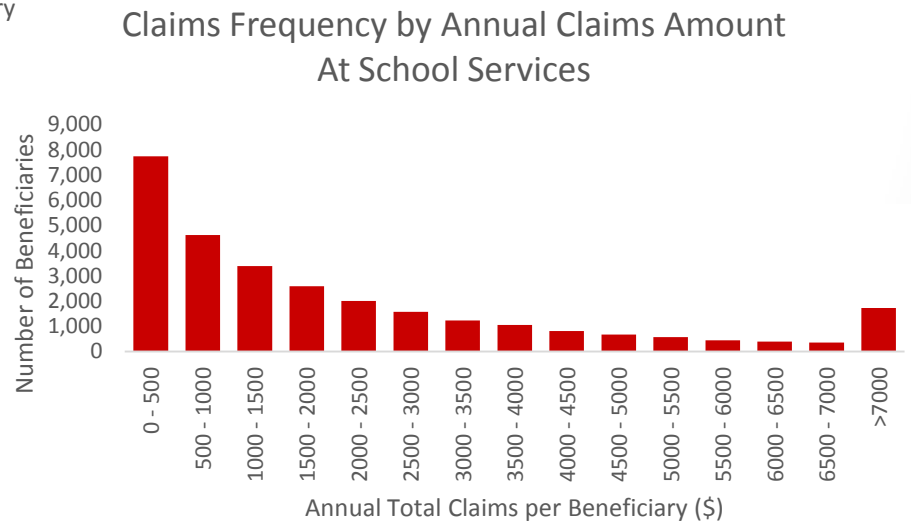
816,000 Claims for All 5 Codes at School, Totaling $64.6MM



H2015 Intervention, Mental Health Professional
H0004 Individual Counseling
H2017 Rehabilitative Day Service
90853 Group Outpatient Psychotherapy
90847 Family Medical Psychotherapy

Most Students Average Fewer than 3 Claims per Month ($1,500 for the Year)





H2015	Intervention, Mental Health Professional
H0004	Individual Counseling
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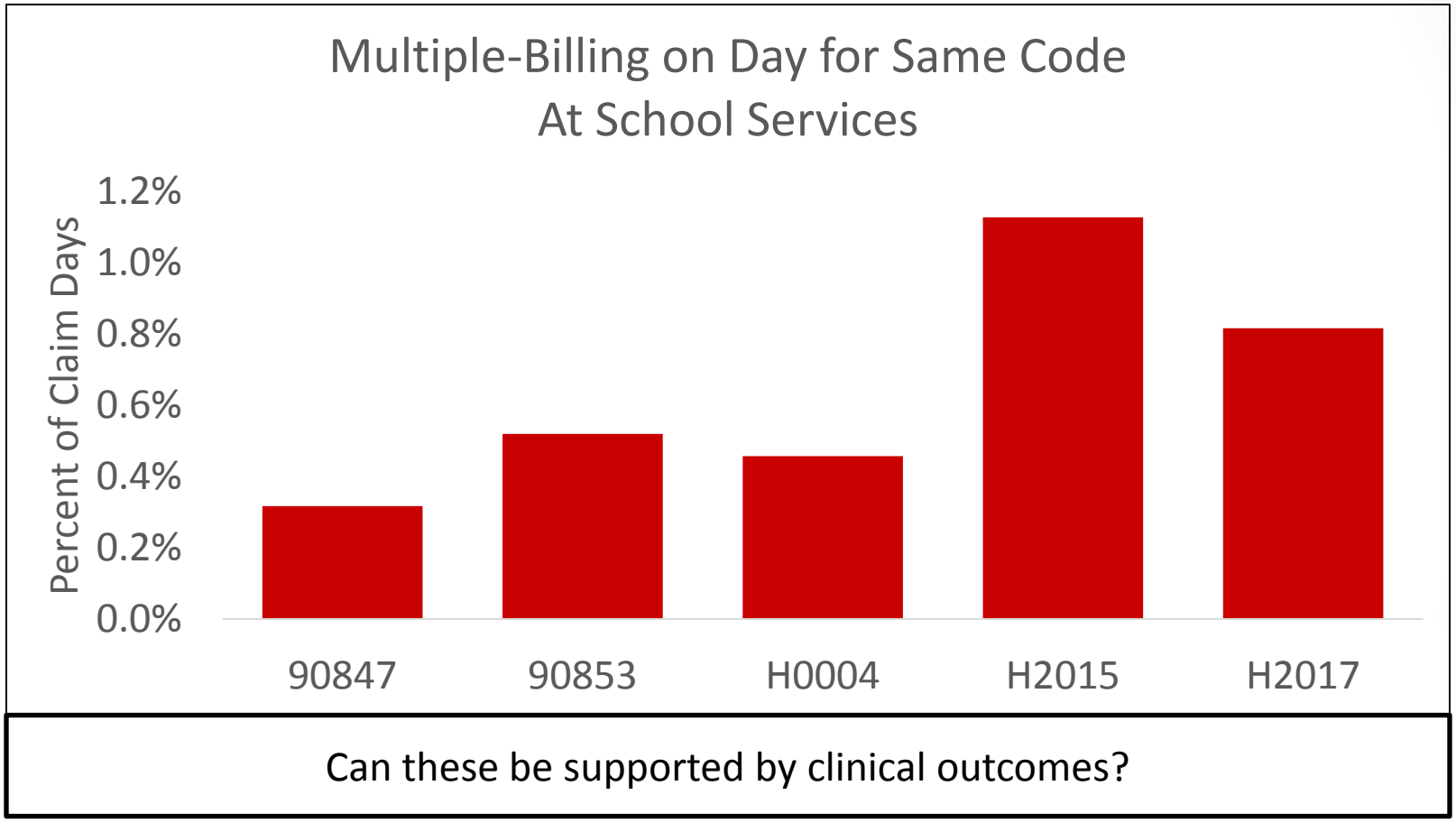
90853	Group Outpatient Psychotherapy
90847	Family Medical Psychotherapy

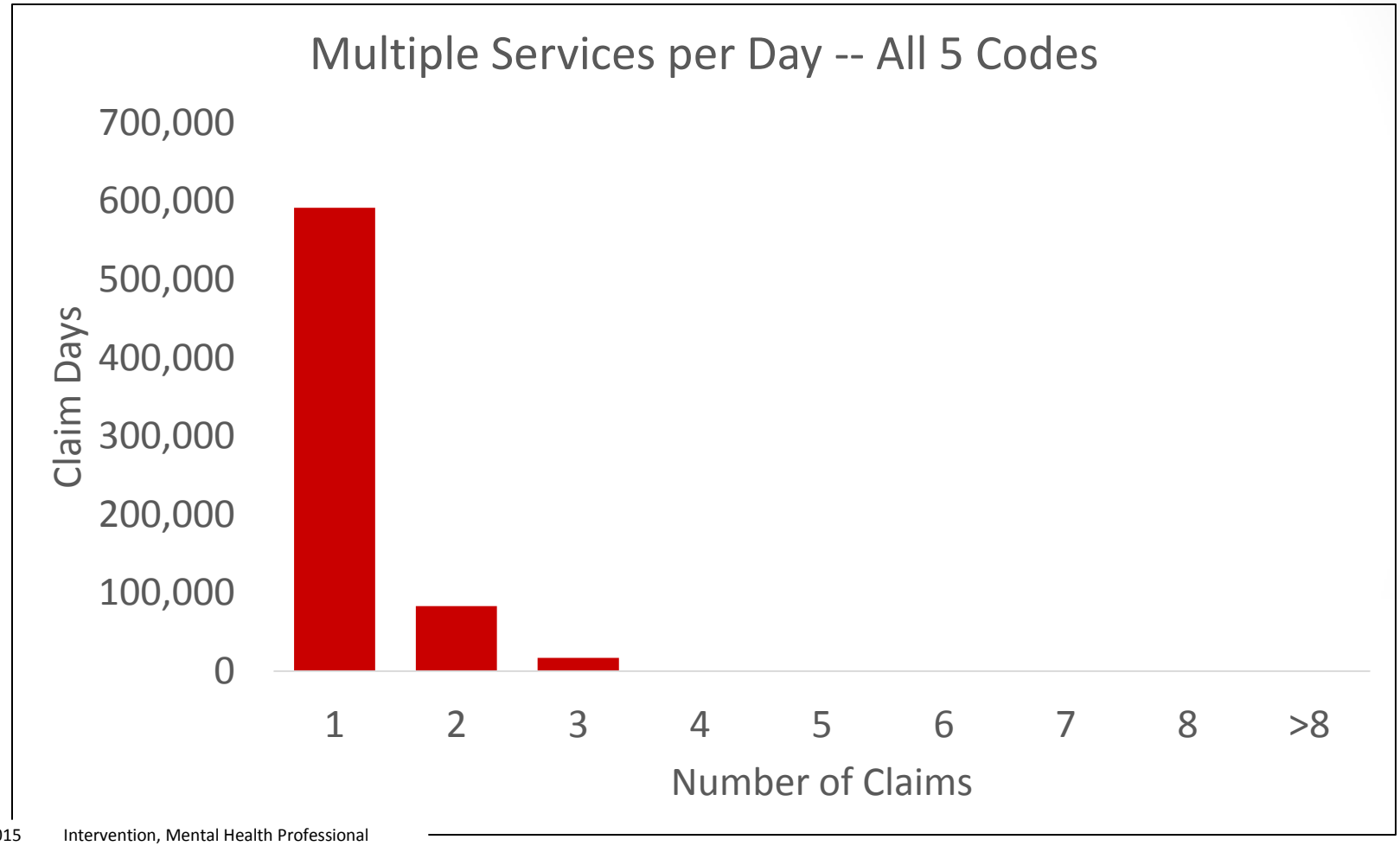
TSG Found 6,300 Claims for Same Service on Same Day at School



Can these be supported by clinical outcomes?

H2015	Intervention, Mental Health Professional
H0004	Individual Counseling
H2017	Rehabilitative Day Service
90853	Group Outpatient Psychotherapy
90847	Family Medical Psychotherapy

15% Multiple Claims on Same Day—All 5 Services



H2015	Intervention, Mental Health Professional
H0004	Individual Counseling
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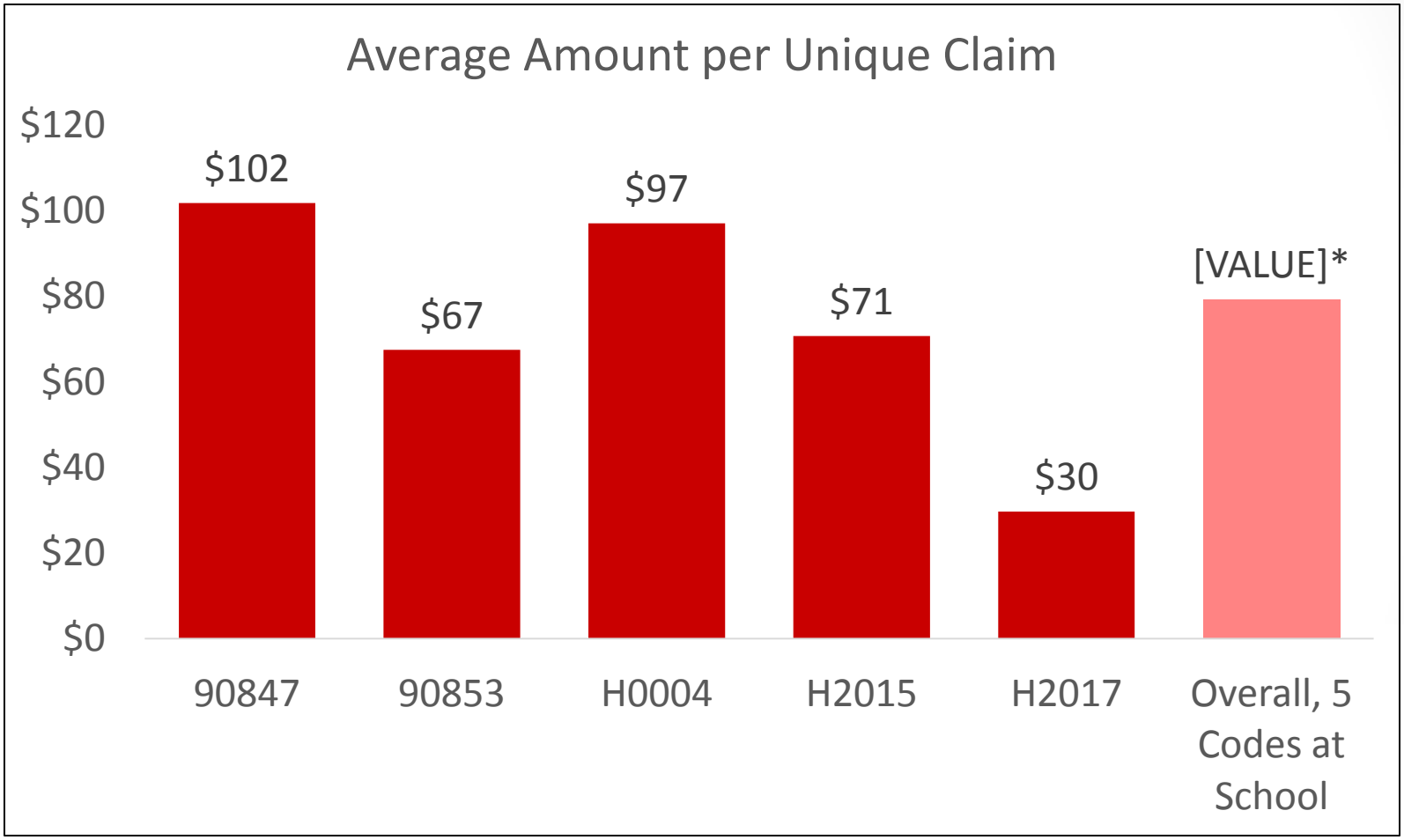
Average Claim Amount – At School Services



H2015	Intervention, Mental Health Professional
H0004	Individual Counseling
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90853	Group Outpatient Psychotherapy
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* Differs from the average used for monetizing Theory 1, as this is based on the 5 codes, at school

Estimating Impact of Multiple School-Based Claims

- Number of multiple claims:
  - Claims - 816,091
  - Claim Days - 693,049
  - Claims in addition to one per day - 123,042
- Amount of Claim
  - Weighted average of all school-based claims - $79
- Estimated effect of multiple-claims on a day

  123,000 * $79 = $9.8 MM

Theories 2 & 3: Not Directly Supported, But Highlight a Opportunity

- The theory that students get more than 6 hours of service is not supported, the average amount claimed for days when there is a claim is $93 (across all 5 services)
- However, we found 6,300 instances of more than one claim for the same service on a day. If this is not clinically supported, the opportunity would be $600K
- We also found $10MM worth of instances of multiple bills for other codes on the same day. This is already included in the amount for Theory 1

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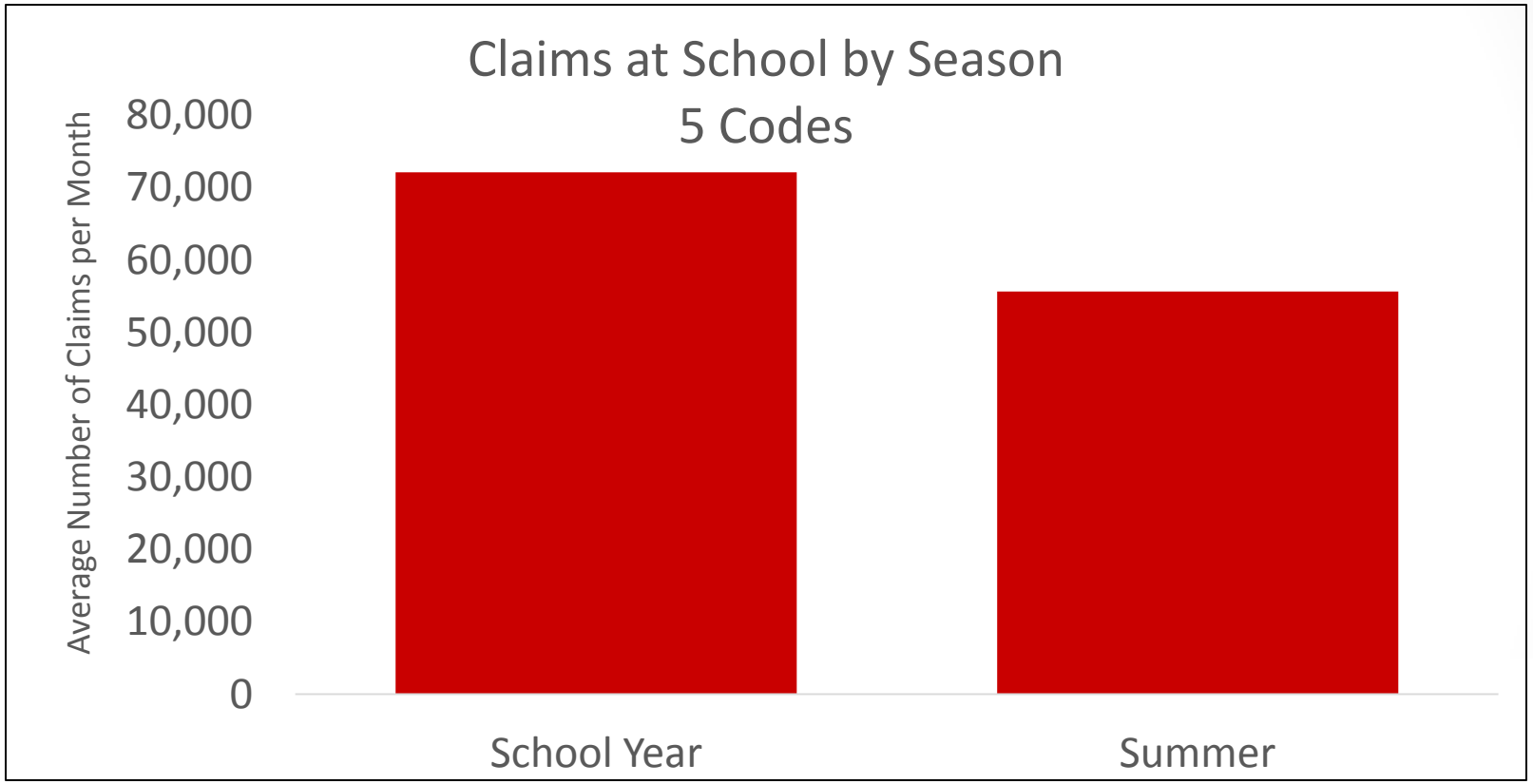
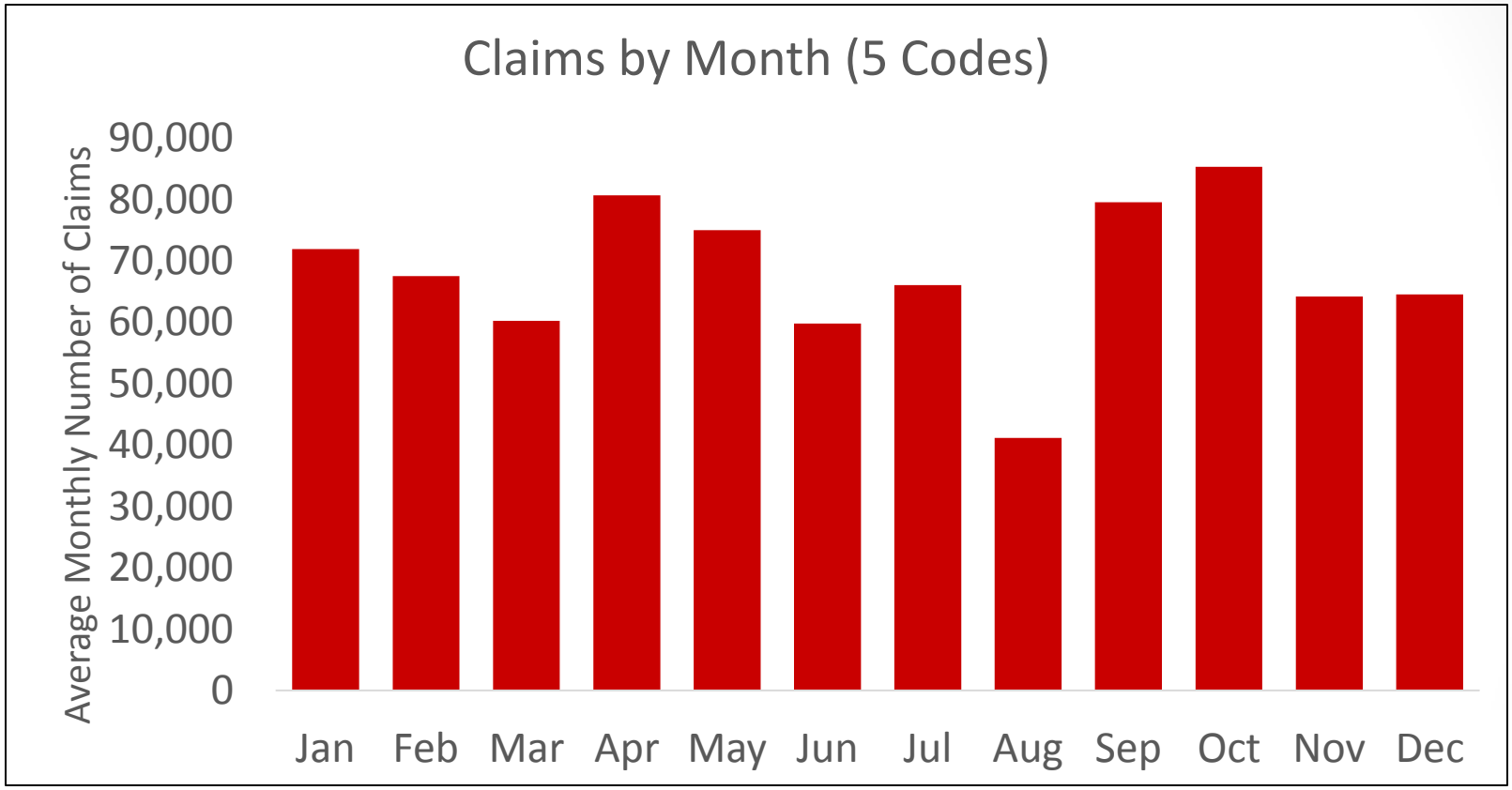
For All 5 Codes, Claims Decrease by Only 23% in the Summer



Average monthly claims *amount* decreases from $5.7MM to $4.3MM (23% decrease)

H2015	Intervention, Mental Health Professional
H0004	Individual Counseling
H2017	Rehabilitative Day Service
90853	Group Outpatient Psychotherapy
90847	Family Medical Psychotherapy

At School Claims by Month



Monthly claim volume decreases from beginning to end of each quarter (except September). Might services be influenced by something other than clinical outcomes?

Why do Claims Drop 23%?

- Are schools open to host Behavioral Health services during the summer?
- Are the students attending summer school?
- What is the nature of the need being filled? Does this change in the summer? If services decrease by 23%, then:
  - Are providers failing to provide adequate services in the summer (to meet the constant needs), or
  - Are providers over-providing during the school year, during a time when students also have teachers and school staff to help with guidance?
  - Are other services replacing school-based services?

Theory 4: Disproved, but Raises a New Question

- During summer, students receive *less, not more* treatment than during the school year.

However:

- Providers are still claiming for 77% as many services at school, when schools are largely not open

What is the clinically effective level of services at school to achieve the best outcome? How would we know? Are these services being rendered at the school during the summer?

Explaining the Summer Findings

- Possibility A: This could be a coding error—services are being provided, just not at school. If so, why is this coding error not being caught? Are there other coding errors?
- Possibility B: Maybe schools are hosting Behavioral Health services in the summer. If so, is there a cost to the State in extra education expenses?
- Possibility C: At-School services do in-fact decline during the summer and are not replaced by other services. If so, are the level of services needed during school year? What about impact on outcomes with lower service during summer?

- Raises a question about the clinical value of all $64MM of at-school services

Additional Finding: Medicaid lacks the Ability to Assess Outcomes

Potentially changing rules about multiple claims on a day, or about at-school services should *not reduce outcomes.* But, how would we know?

	Expected Outcome	Reporting Requirement per Manual
H0004	Reduce or alleviate identified symptoms, maintain or improve level of functioning, or prevent deterioration	• Beneficiary's response to intervention that includes current progress or regression and prognosis • Any revisions indicated for the master treatment plan, diagnosis, or medication(s) • Plan for next individual therapy session
H2015	Improve the beneficiary's progress toward specific goal(s) and outcomes	
H2017	Enhance a youth's functioning in the home, school, and community with the least amount of ongoing professional intervention	Beneficiary's participation and response to the intervention

Outcomes (cont.)

	Expected Outcome	Reporting Requirement per Manual
90847	Identify and address marital/family dynamics	• Beneficiary (and spouse/family's) response to intervention • Any changes indicated for the master treatment plan • Plan for next session
90853	Beneficiary's response to the Intervention, Mental Health Professional	

How can outcomes be assessed? How would we know if more than one claim on a day (or at-school services in the summer) is achieving the objectives in the Master Treatment Plan?

Future Consideration: How are Other Behavioral Health Services Managed?

Code	Description	2014 Amount
H2015	Intervention, Mental Health Paraprofessional	87,168,612
H0004	Individual Behavioral Health Counseling & Therapy, Per 15 Minutes	78,111,549
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	Other	55,169,807
	Total	464,686,509

How can Medicaid know that these (bold) services are managed for outcomes. These represent an additional $158MM or 34% of Behavioral Health claims

* TSG has learned that the OMIG may be investigating speech therapy. However, we do not know the scope or focus of the investigation. Also, note that speech therapy is not an RSPMI service

Some Specific Questions Arise About the Additional Claim Categories

- Are providers using a process of assessing effectiveness of Speech Therapy, akin to that required by Medicare…halting services when speech outcomes are not improving? What is the likely impact of requiring improved outcomes? (code 92507)
- What is the clinical outcome from $60MM spent on 15-25 minute office visits (which are used for pharmaceutical management)? (codes 99213 & 99214). The manual currently requires no report on effectiveness of these services
- Why is Medicaid spending $14MM evaluating psychiatric records, then another $16MM explaining the evaluation? Do these affect outcomes…are they a form of communication between providers? (codes 90885 & 90887)

Summary of Findings

- On 23% of days when there is a claim, we found multiple claims for the same beneficiary. That equates to a $40MM opportunity unless there is clinical evidence of outcomes
- TSG found instances in which the same code was claimed for a patient more than once in a day. Is this allowed by policy? Is it clinically supported to increase outcomes?
- School-based services appear to have a slightly LOWER rate of multiple claims on a day. Thus, the multiple claims on a day is more general than merely schools
- TSG did not observe outcome metrics that could be used to demonstrate clinical efficacy of multiple claims on a day or summer at-school services
- Five more areas need investigation. They represent the next 34% of Behavioral Health claims

Estimating the Potential

Opportunity	Potential
Eliminate multiple billing for same code on a day	$40MM
Eliminate multiple billing for other codes on a day	$10MM* (not additive)
Set "right" level of service for students – given that overall services drop by only 23% during the summer	Could range from $64MM savings (unlikely) to $5MM added cost (if underserved in summer)
Possible effect of reduction	$20-30M

* Includes findings of all three Theories

Action Items

1. Implement immediate changes to begin managing Behavioral Health costs—to be implemented in 2-6 months
2. Start right now on transforming the RSPMI benefit to evidence-based and best practice services for SPMI Adults and SED Children/Adolescents—to be implemented in 6-8 months
3. Investigate several specific questions about the five remaining major cost elements in Behavioral Health

1. Implement Immediate Changes To Begin Managing Behavioral Health

- Create new policy requiring **advance approval** for more than one of the following in a given day: H2017, H2015, 90847, 90853, H0004, others as appropriate
- Require **advance approval** for a second instance of the same code on a given day (especially for H2017, H2015, 90847, 90853, H0004, others as appropriate). That approval should be as part of a care plan (below) and tied to outcome metrics (also below)
- Create **measurable outcome metrics** for each service type. These could be akin to the measures used by Medicare for PT/OT/Speech. Add required reporting of metrics to the list of reporting requirements (manual)

Immediate Changes (cont.)

- Develop and implement a BH quality system including **auditing** Master Treatment Plans, reported results of services, and care management outcomes. There should be two types of audits: systemic to discover system deficiencies and compliance to find variance from policy and effective practice
- Develop and implement new **penalties** associated with policy and audits

Implement these within 6 months

2. Transform RSPMI to Evidence-Based And Best Practice Services

- Goal: Improve clinical effectiveness, cost efficiency, and care management
- Change the Medicaid Manual definition of “Medical Necessity” to enable effective care management strategies in all settings.
- Transform RSPMI into an adult behavioral health rehabilitative benefit and a child/adolescent behavioral health benefit.
- Implement research-based evidence based behavioral health treatments and known best practices effectively used in other states for the adult and child/adolescent benefit.

Transform RSPMI to Evidence-Based And Best Practice Services (cont.)

- Re-design the RSPMI benefit through an inclusive stakeholder process that is led by an Independent Facilitator and supported by independent behavioral health clinical expertise for adults and children/adolescents
- Develop and implement an Arkansas approach to coordinating Mental Health Rehabilitation Option services with Arkansas State Hospital, private psychiatric hospitals, and RTCs at admission and discharge.
- Develop and implement an Arkansas approach to coordinate the BH needs of children and adolescents in Foster Care across IP and OP in a multi agency wrap around model.

Transform RSPMI to Evidence-Based And Best Practice Services (cont.)

- Require the use of evidential BH acuity assessment instruments administered by qualified independent professionals for adults and children/adolescents.
- Require the individual Master Treatment Plan and level of service (duration, amount, scope) to be based on acuity level resulting from the independent assessment and the patient's immediate circumstances.
- Require an independent qualified organization, such as an ASO or MCO, to manage the Arkansas Mental Health Rehabilitation Option and Medicaid paid inpatient services with a level of risk across the system.

Transform RSPMI to Evidence-Based And Best Practice Services (cont.)

- Develop and require Outcome measures (including consumer satisfaction) for all services based on a combination of Institute of Medicine, National Committee for Quality Assurance/HEDIS, and SAMHSA measures. The outcomes system should include training, allowance for corrective action, accountability, and tiered consequences for non-performance.
- DHS must assure that the Division of Medical Services and Behavioral Health Services work in partnership to assure Medicaid Policy is developed based on behavioral health expertise.

Transform RSPMI to Evidence-Based And Best Practice Services (cont.)

- DHS, DBHS, and DMS should be empowered to develop a comprehensive plan to transform the current RSPMI benefit model as recommended, develop a planning and implementation timeline, develop a project management framework, empower a project manager with appropriate level of expertise and authority and submit to the Arkansas Health Reform Task Force for approval within 60 days.

Implement these within 8 months

3. Investigate Specific Questions About 5 Additional Cost Elements

Code	Question	Approach
92507 - Individual Speech Therapy	Impact of requiring improved Speech Therapy outcomes	Review Medicare process. Review current Medicaid provider assessment reports/records. Develop an outcome-based reporting process. Develop policy to require outcomes or halt services
99213 & 99214 – Office visit	How are these having a $60MM effect on outcomes?	Investigate provider reports to segment types of visits. Define a way to link evaluations to outcomes. Develop new policy requiring impact on outcomes
90855 & 90857* – Psychiatric Evaluation	How are these linked to outcomes?	Investigate provider reports to segment types of activities being performed. Define a way to link evaluations to outcomes. Develop new policy requiring impact on outcomes

* These two codes are for services outside RSPMI