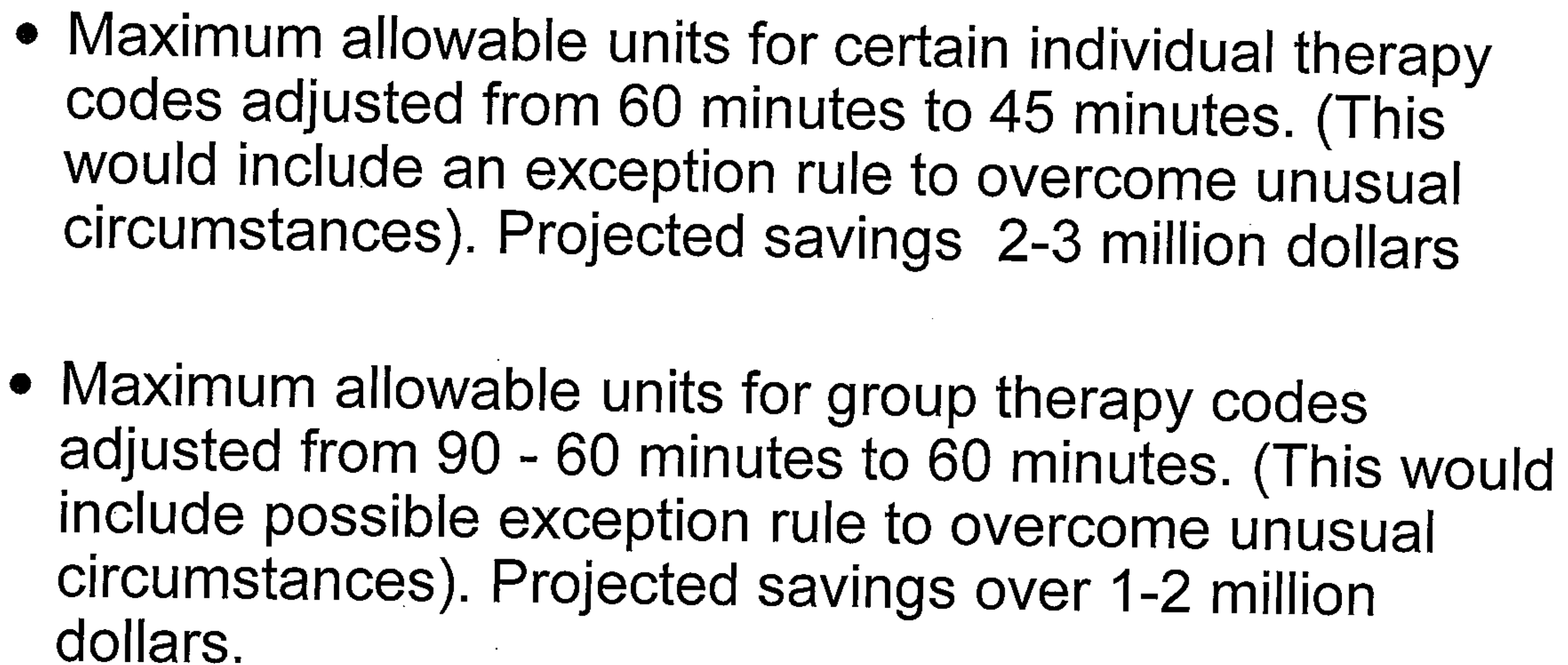
Handout # 4
Re: E-3

Alliance for Health
Improvement

Cost Savings Measures
Rehabilitative Services for Person with Mental Illness (RSPMI)

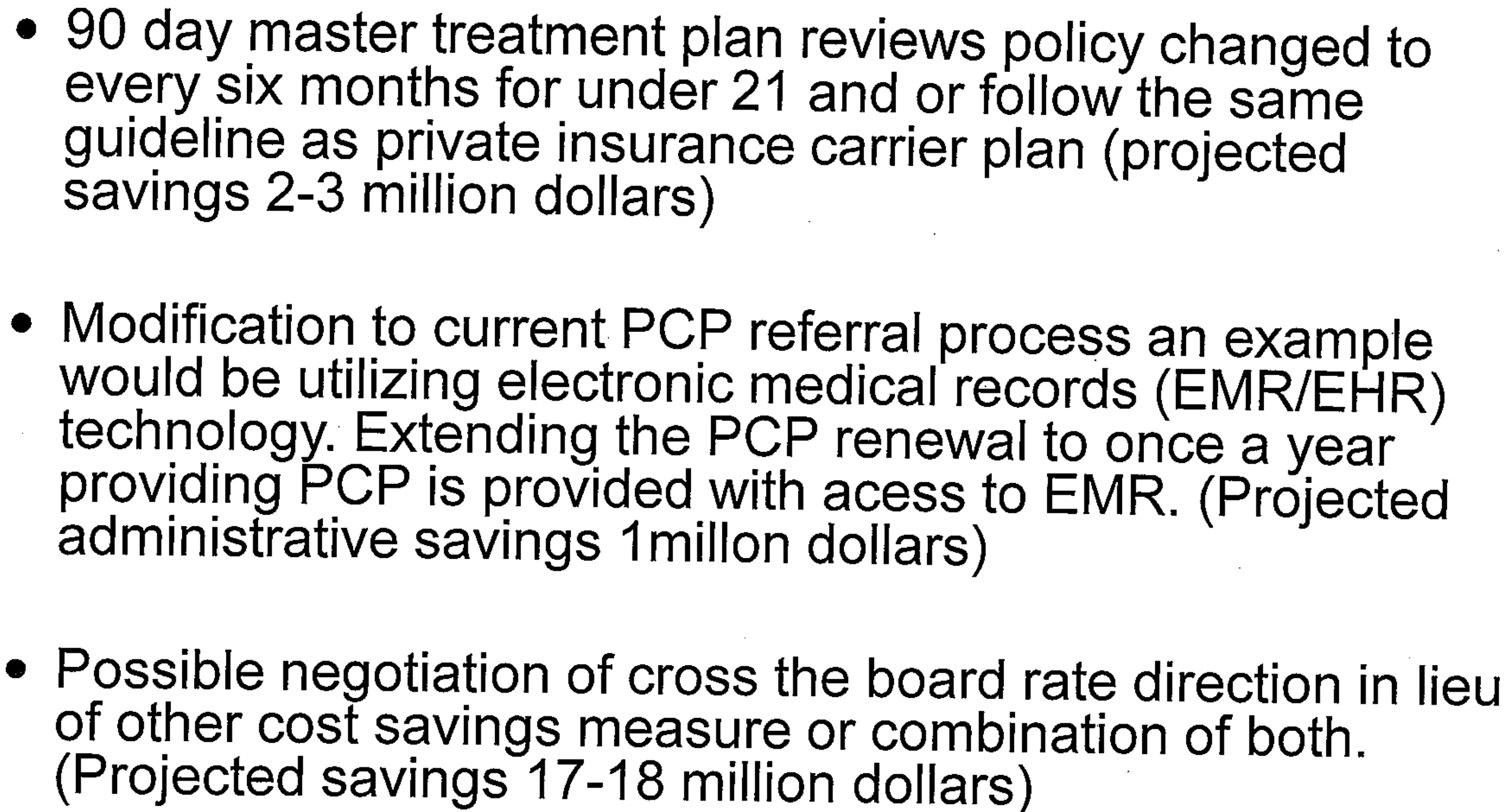
Arkansas Health Reform Legislative Task Force

September 16, 2015



- Maximum allowable units for certain individual therapy codes adjusted from 60 minutes to 45 minutes. (This would include an exception rule to overcome unusual circumstances). Projected savings 2-3 million dollars

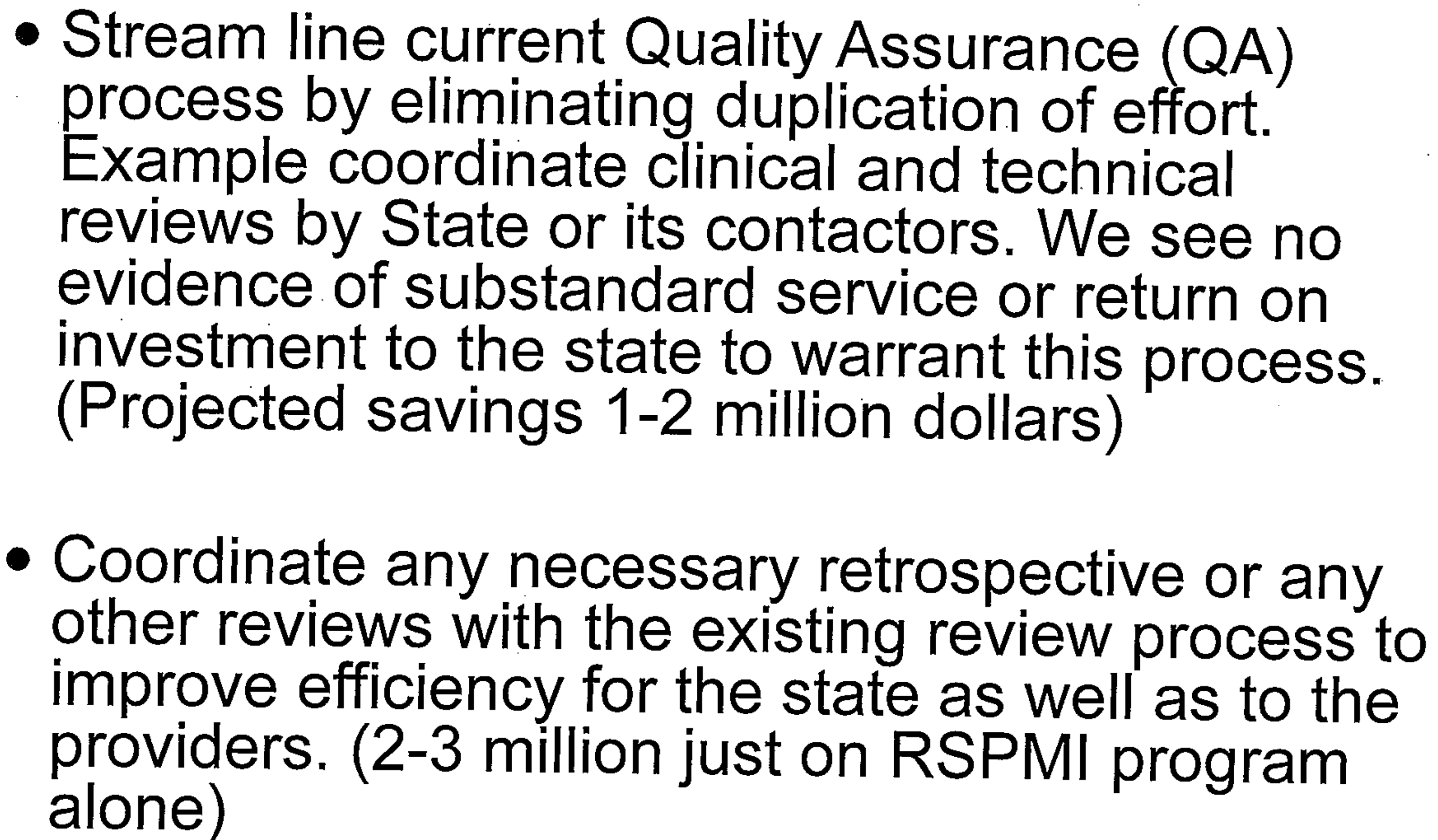
- Maximum allowable units for group therapy codes adjusted from 90 - 60 minutes to 60 minutes. (This would include possible exception rule to overcome unusual circumstances). Projected savings over 1-2 million dollars.



- 90 day master treatment plan reviews policy changed to every six months for under 21 and or follow the same guideline as private insurance carrier plan (projected savings 2-3 million dollars)

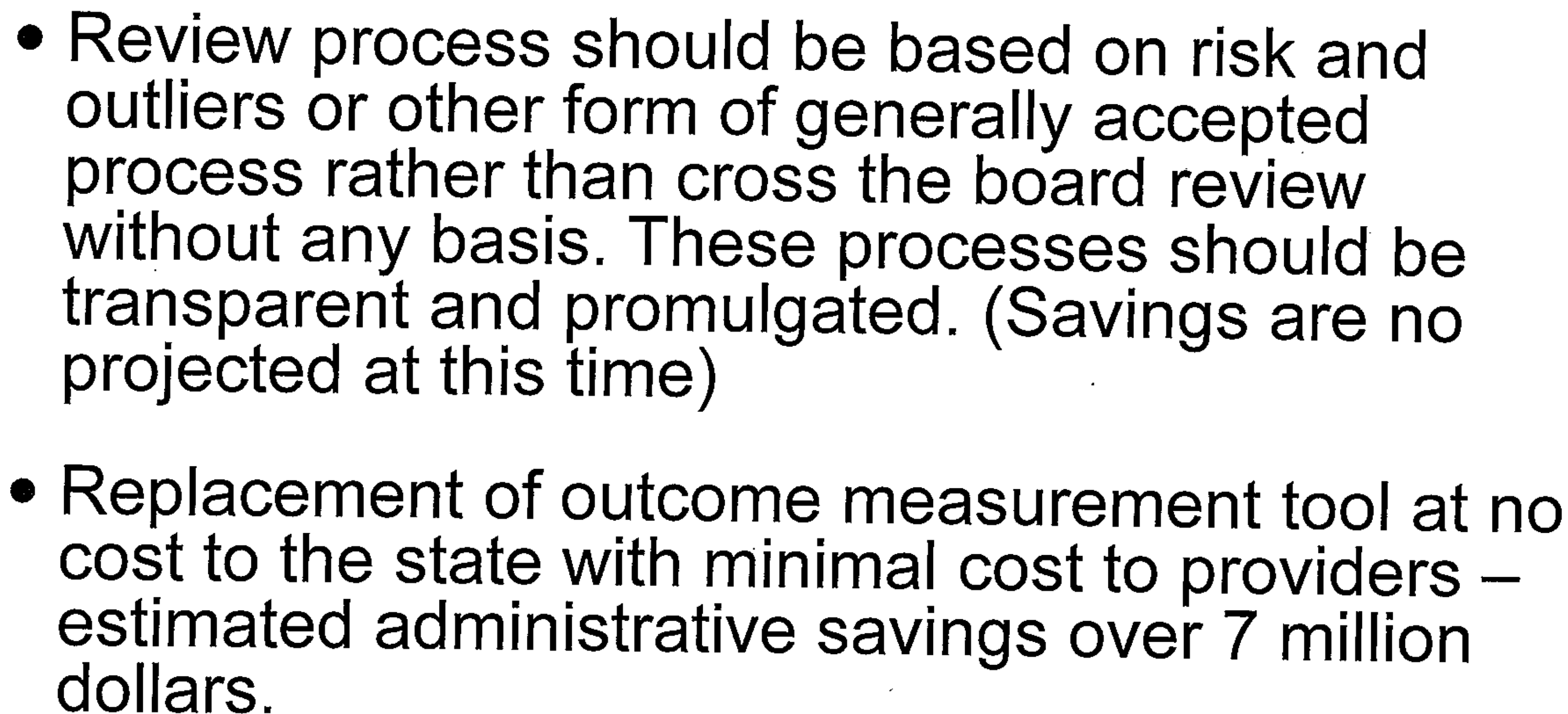
- Modification to current PCP referral process an example would be utilizing electronic medical records (EMR/EHR) technology. Extending the PCP renewal to once a year providing PCP is provided with acess to EMR. (Projected administrative savings 1millon dollars)

- Possible negotiation of cross the board rate direction in lieu of other cost savings measure or combination of both. (Projected savings 17-18 million dollars)

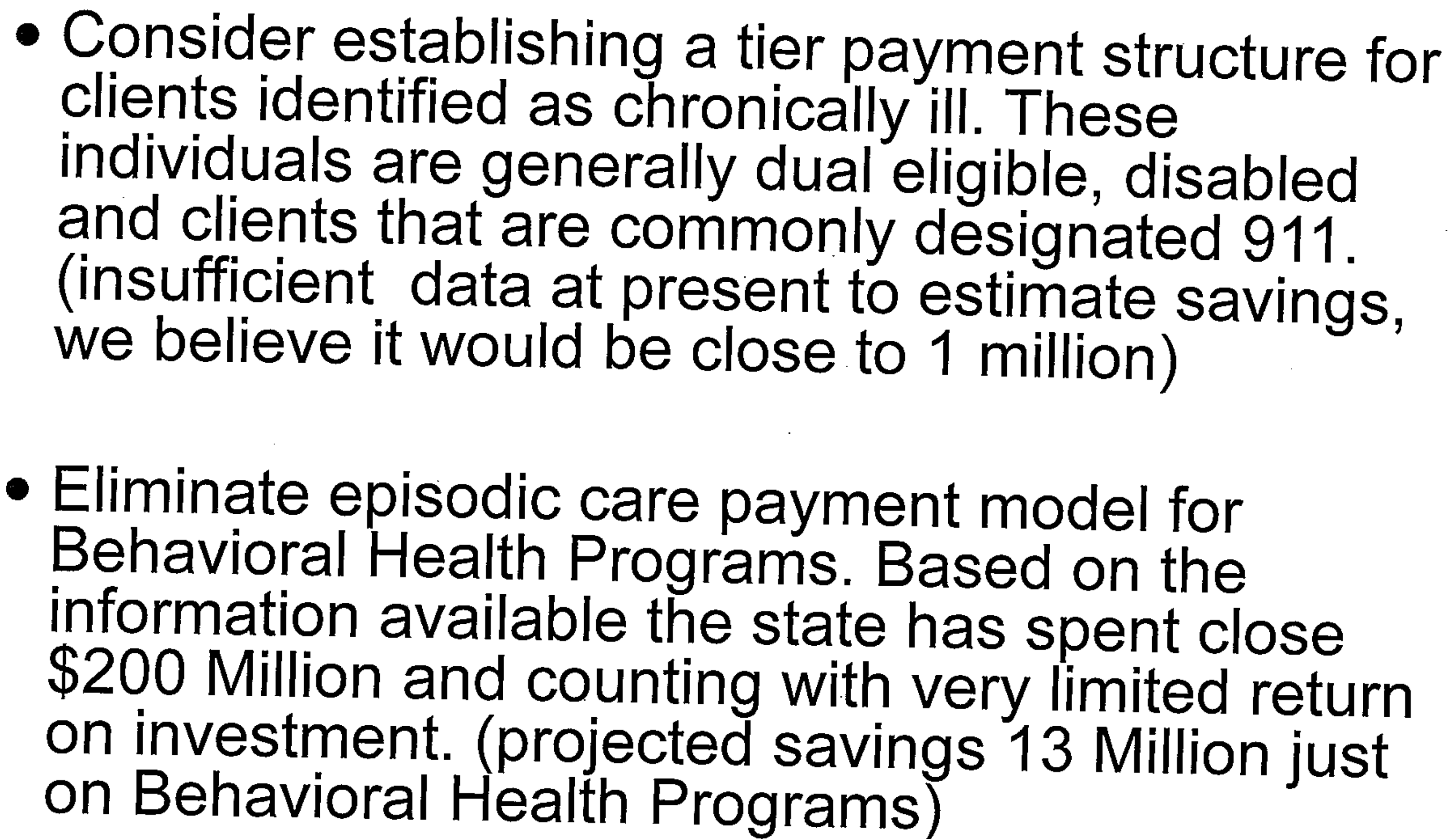


- Stream line current Quality Assurance (QA) process by eliminating duplication of effort. Example coordinate clinical and technical reviews by State or its contactors. We see no evidence of substandard service or return on investment to the state to warrant this process. (Projected savings 1-2 million dollars)

- Coordinate any necessary retrospective or any other reviews with the existing review process to improve efficiency for the state as well as to the providers. (2-3 million just on RSPMI program alone)

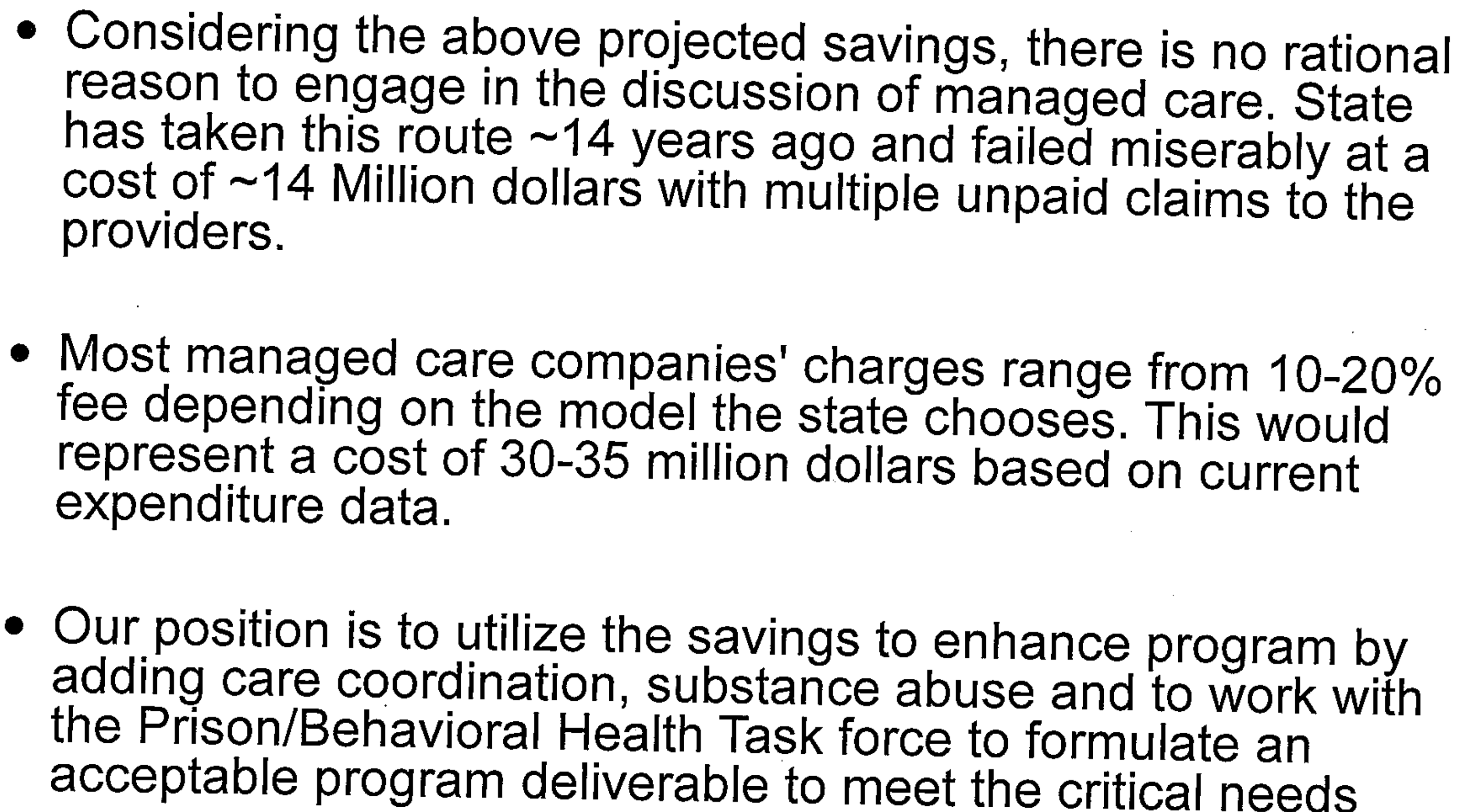


- Review process should be based on risk and outliers or other form of generally accepted process rather than cross the board review without any basis. These processes should be transparent and promulgated. (Savings are no projected at this time)
- Replacement of outcome measurement tool at no cost to the state with minimal cost to providers – estimated administrative savings over 7 million dollars.



- Consider establishing a tier payment structure for clients identified as chronically ill. These individuals are generally dual eligible, disabled and clients that are commonly designated 911. (insufficient data at present to estimate savings, we believe it would be close to 1 million)

- Eliminate episodic care payment model for Behavioral Health Programs. Based on the information available the state has spent close $200 Million and counting with very limited return on investment. (projected savings 13 Million just on Behavioral Health Programs)



- Considering the above projected savings, there is no rational reason to engage in the discussion of managed care. State has taken this route ~14 years ago and failed miserably at a cost of ~14 Million dollars with multiple unpaid claims to the providers.

- Most managed care companies' charges range from 10-20% fee depending on the model the state chooses. This would represent a cost of 30-35 million dollars based on current expenditure data.

- Our position is to utilize the savings to enhance program by adding care coordination, substance abuse and to work with the Prison/Behavioral Health Task force to formulate an acceptable program deliverable to meet the critical needs

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Questions ?

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