Bureau of Legislative Research

Arkansas Health Care Reform Task Force

TSG Update Report

December 16, 2015

Health Care Independence Program Breakout

Private Option / Health Care Independence Breakout

FPL Categories	Total	% total	Higher Ed	% total	UI Benefits	% total	SNAP	% total	TANF	% total	SNAP & TANF	% total
0-50%	148,849	59.1%	1,216	0.5%	2,336	0.9%	57,276	22.8%	558	0.2%	404	0.2%
50-100%	61,169	24.3%	758	0.3%	1,316	0.5%	22,174	8.8%	229	0.1%	179	0.1%
100-138%	39,517	15.7%	452	0.2%	920	0.4%	7,822	3.1%	93	0.0%	69	0.0%
Over 138%	2,135	0.8%	15	0.0%	44	0.0%	285	0.1%	4	0.0%	3	0.0%
TOTAL	251,670	100.0%	2,441	1.0%	4,616	1.8%	87,557	34.8%	884	0.4%	655	0.3%

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0-50%	148,849	59.1%	1,216	49.8%	2,336	50.6%	57,276	65.4%	558	63.1%	404	61.7%
50-100%	61,169	24.3%	758	31.1%	1,316	28.5%	22,174	25.3%	229	25.9%	179	27.3%
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Notes:

1 *330 members live in households of between 9 and 12 people (.001%), and are not included in the above breakout.*

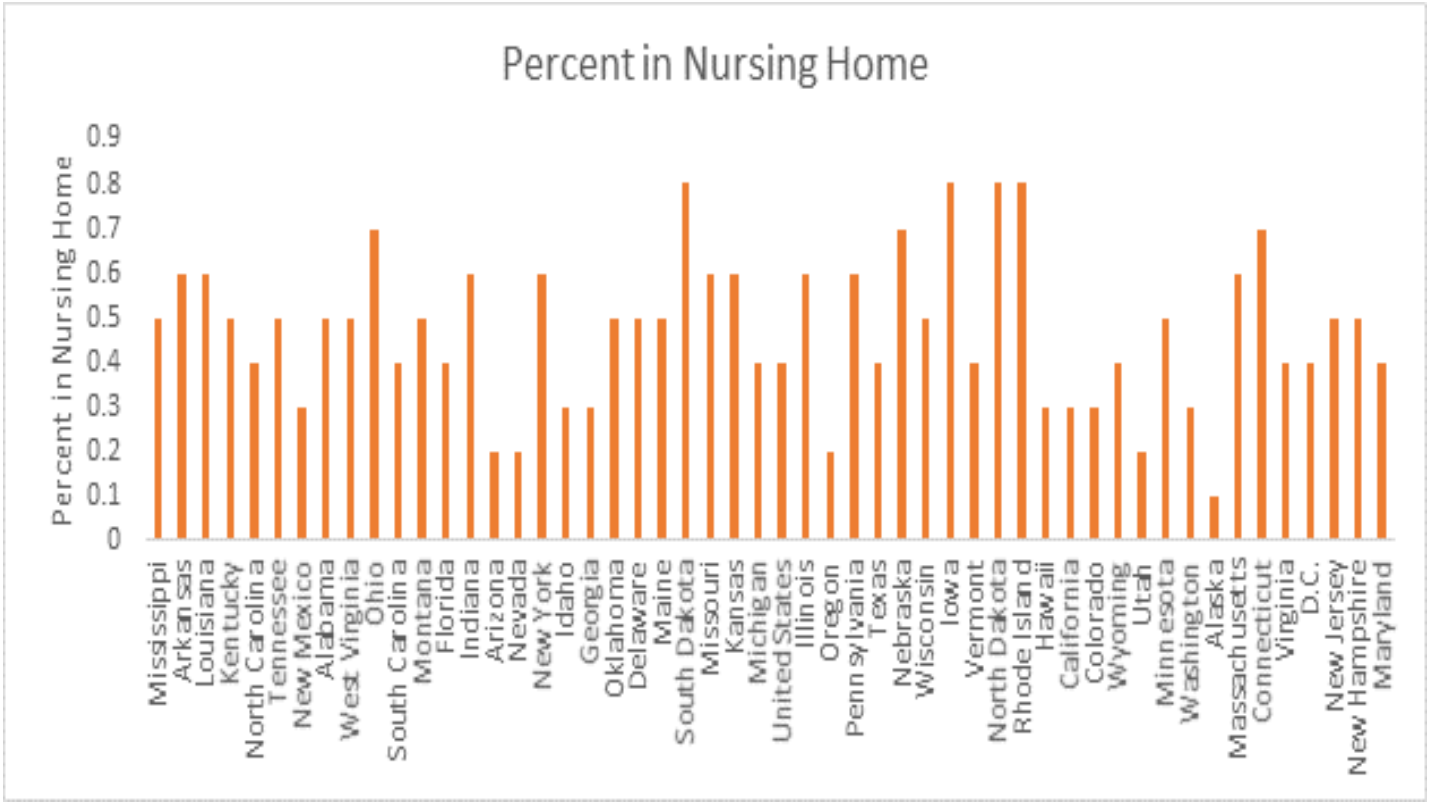
2 *The Over 138% category could include beneficiaries who are being disenrolled upon renewal or beneficiaries enrolled through the Federal Portal and not yet reviewed.*

3 *Monthly Income DOES include UI benefits, but does NOT include SNAP or TANF benefits.*

4 *Only taxable student aid is counted as Income for Higher Ed students. There are other policy constraints on what student aid or scholarship income can be considered.*

5 *There are a small number of records which apparently have data entry errors (~80 records). DHS/DCO has or is fixing these errors.*

State Per Capita Income Does Not Appear To Be a Determining Factor in % of State Population Residing in Nursing Homes (source: CMS 2013 Nursing Home Compendium Data)



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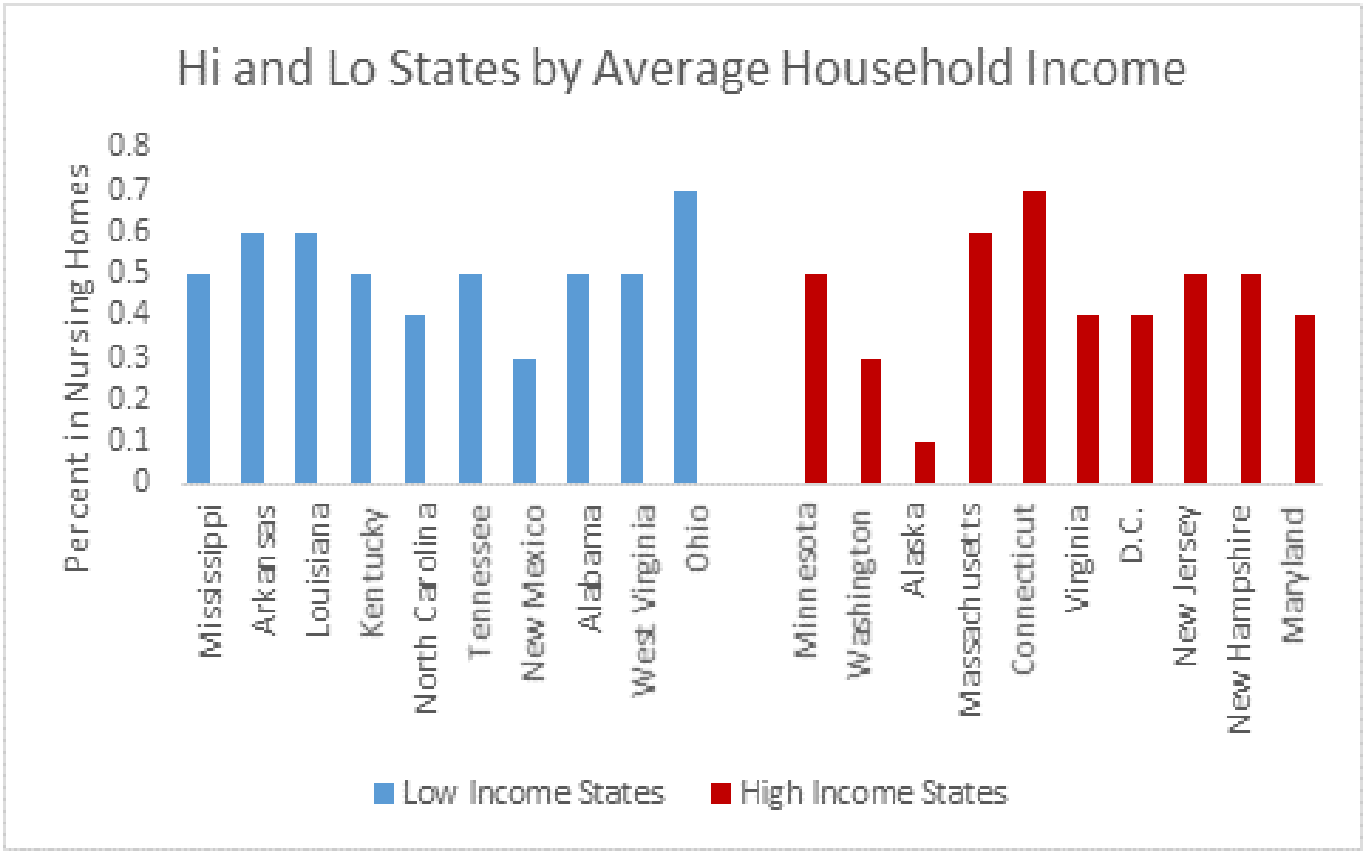
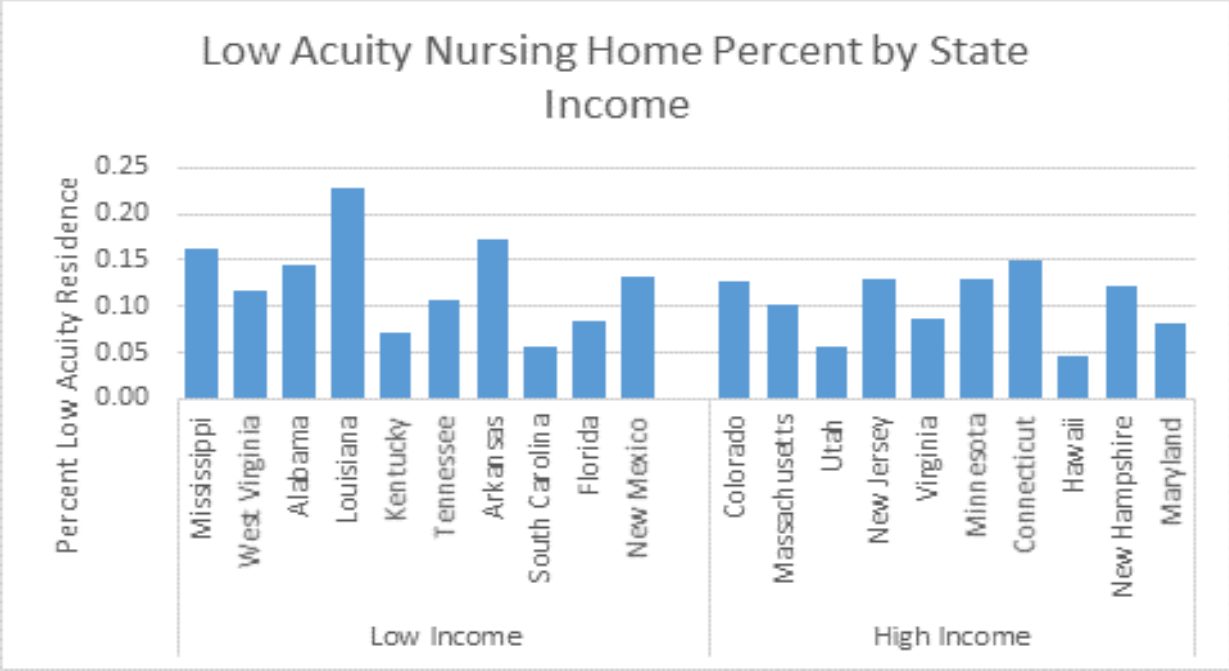


State Per Capita Income Does Not Appear To Be a Determining Factor in % of Low Acuity Residents Residing in Nursing Homes (source: CMS 2013 Nursing Home Compendium Data)



Analysis of Behavioral Health for Multiple Claims on a Day

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

With the Agency, 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.

TSG Investigated Theory 1: Multiple Charges for H2017 (Day Services)

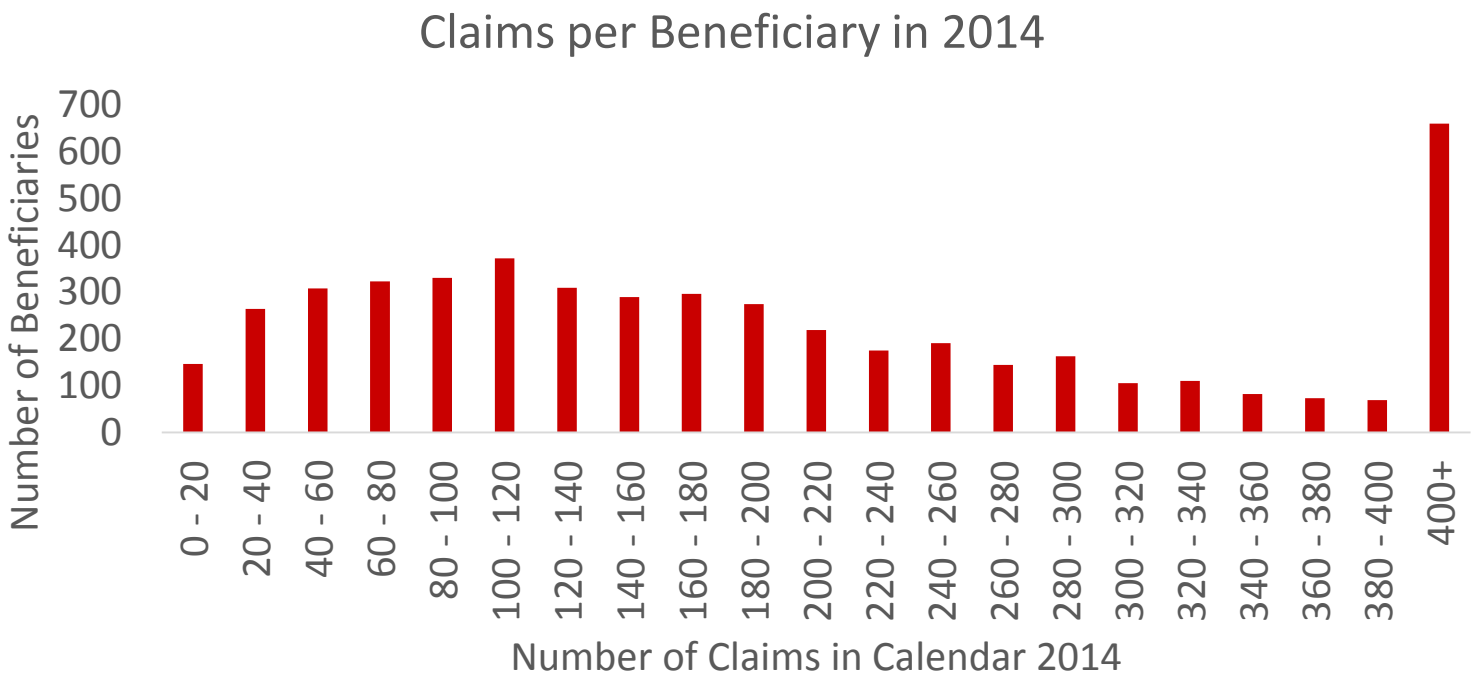
The Data

- All DHS claims for calendar year 2014
- Filtered to include only those with charges coded in the Behavioral Heath area (list, following page)
- Further, filtered to include only beneficiaries with at least one charge during the year for H2017—Rehabilitative Day Service
- Sample: We sorted claims by beneficiaries then used the first 1,004,000 of the 1,425,000 claims
- Then, for deeper analysis, TSG zeroed in on claims for the top 10% of H2017 beneficiaries: 490,000 claims by 494 beneficiaries—day by day, code by code

Behavior Health Charge Codes

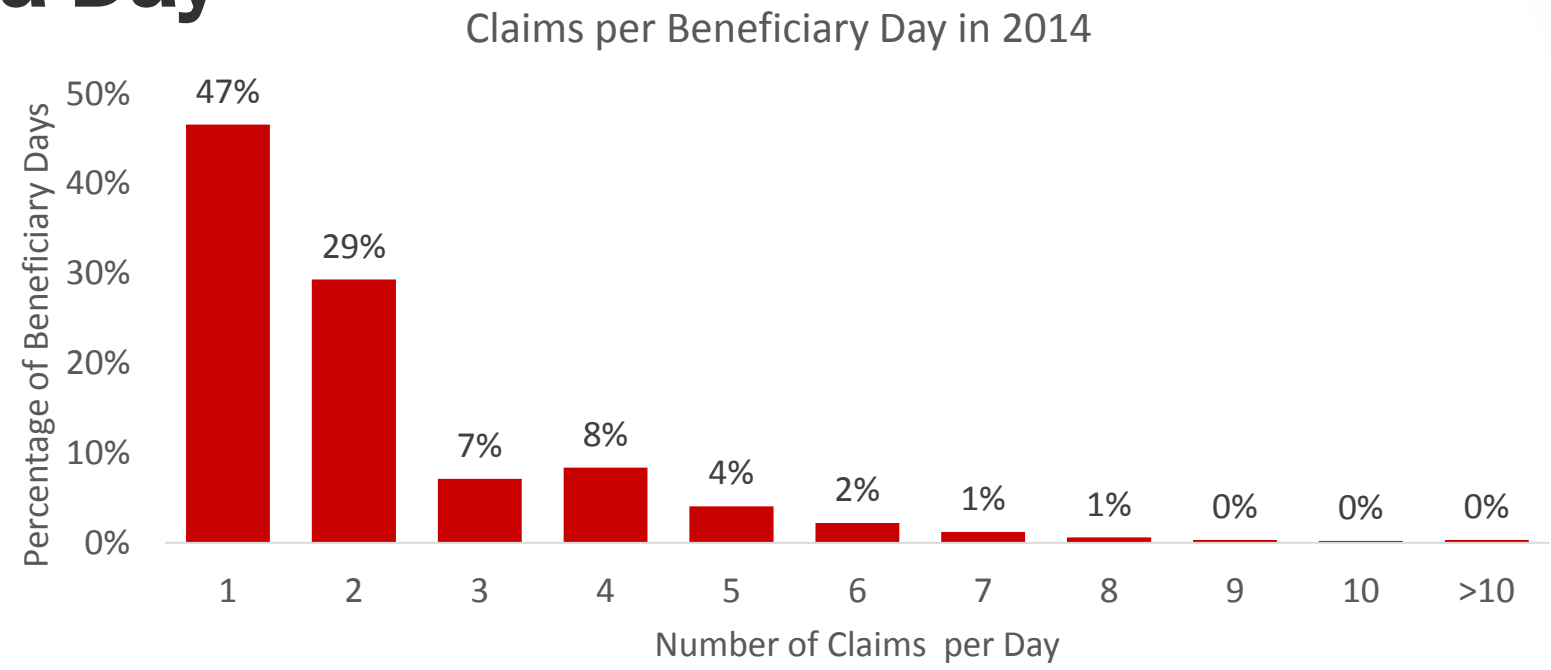
Code	Description	2014 Amount
H2015	Group Intervention, Mental Health Paraprofessional	87,168,612
H0004	Individual Behavioral Health Counseling & Therapy, Per 15 Minutes	78,111,549
92507	Individual Speech Therapy By Slpa	65,348,908
90853	Group Outpatient – Group Psychotherapy	51,079,618
99213	Established 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 Psych Exam Results	15,805,678
90885	Psy Eval Of Records	14,139,721
90847	Family Medical Psychotherapy With The Patient Present.	13,860,035
90846	Family Medical Psychotherapy	6,190,606
99203	Physical Examination	4,961,782
99204	New Patient Office Or Other Outpatient Visit, Typically 45 Minutes	3,524,230
96101	Psychological Testing With Interpretation And Report By Psychologist Or	3,268,509
99212	Established Patient Office Or Other Outpatient Visit, Typically 10 Minutes	3,186,752
H2011	Crisis Intervention Per 15 Minutes	2,910,160
92508	Group Outpatient – Speech Therapy	2,456,652
92506	Speech Evaluation	1,616,356
99202	New Patient Office Or Other Outpatient Visit, Typically 20 Minutes	1,498,565
T1023	Other	2,931,101
H2012	Total	442,061,414

Number of Claims by Beneficiary



The most frequent number of Behavioral Health claims per beneficiary is 100-120

Finding 1: Most Day Services Beneficiaries Claim only Once or Twice a Day

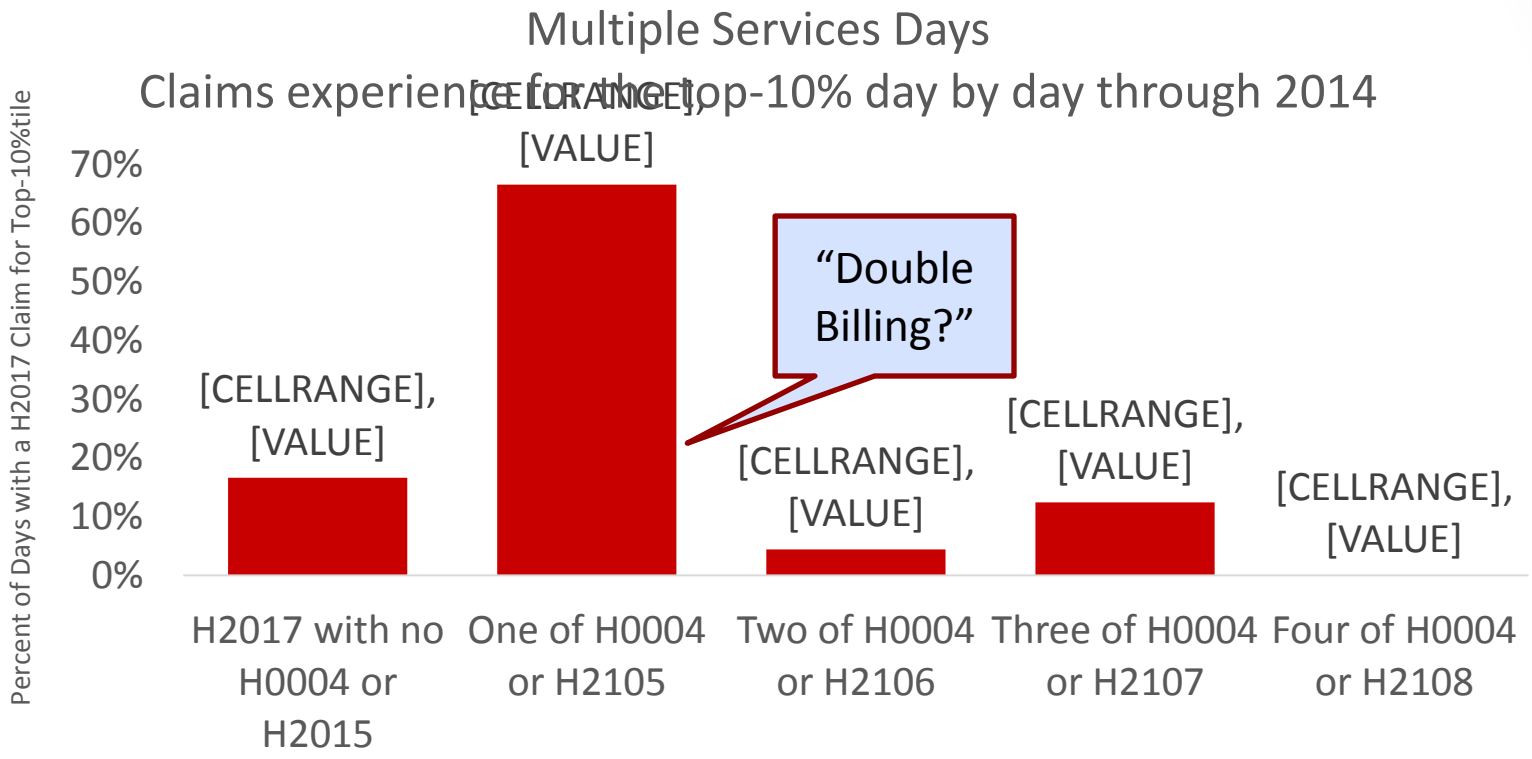


78% of Claim Days had only 1 or 2 Claims—for 53% of beneficiaries with more than one claim, there could be a "same day service" issue

To Zero-in on Daily Claims Activity, TSG Focused on the Top 10%

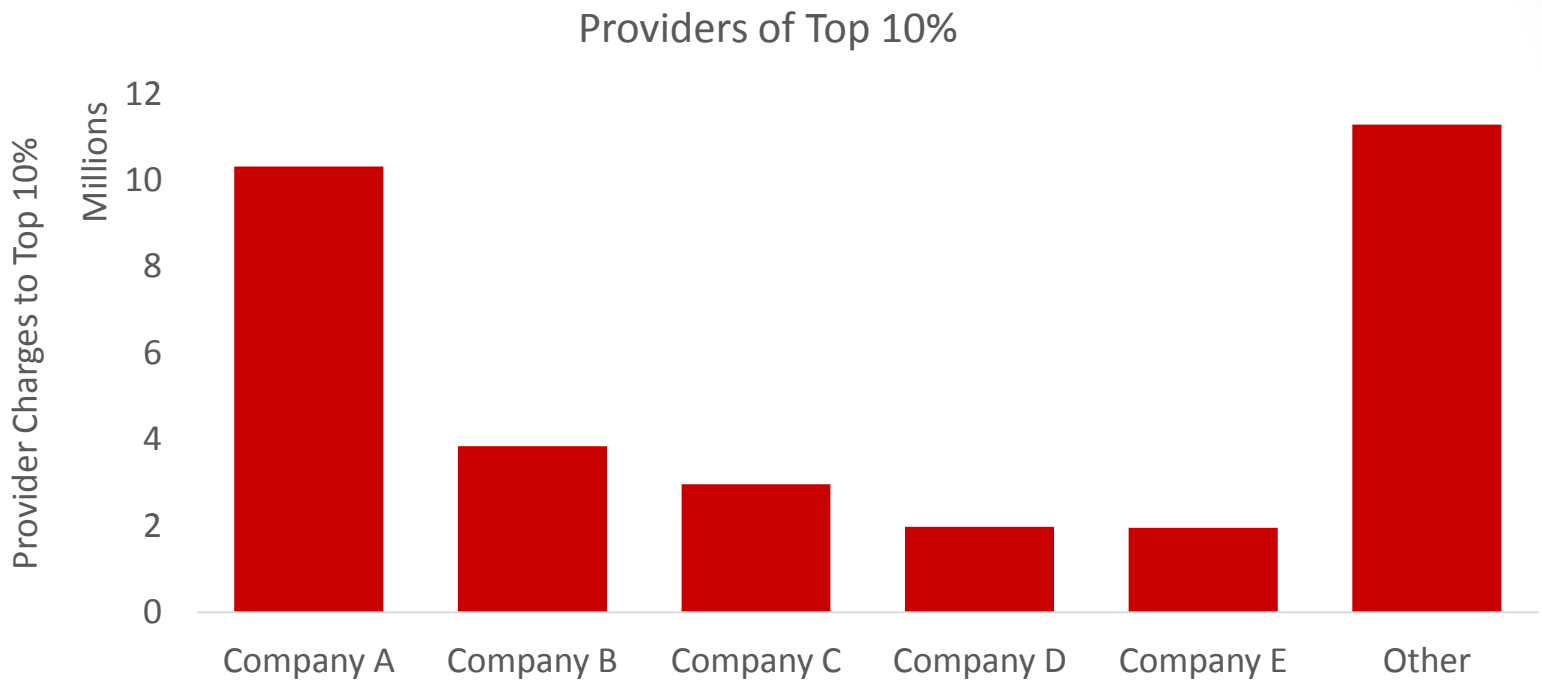
- Sorted beneficiaries by number of claims for 2014
- Selected the top 494 largest number of claims. One beneficiary had 1,411 Behavioral Health claims in 2014!
- This allowed TSG to look at the charge codes of every claim for every day for the Top 10% group over 365 days – 180,000 claiming days
- We observed how many times on each day there were claims for H0004 or H2015 in addition to H2017. We created a simple ratio of Other Services to Day Services…1:1 could be potential "double billing"

Finding 2: Same Day Services Are Substantial Among the Top 10%



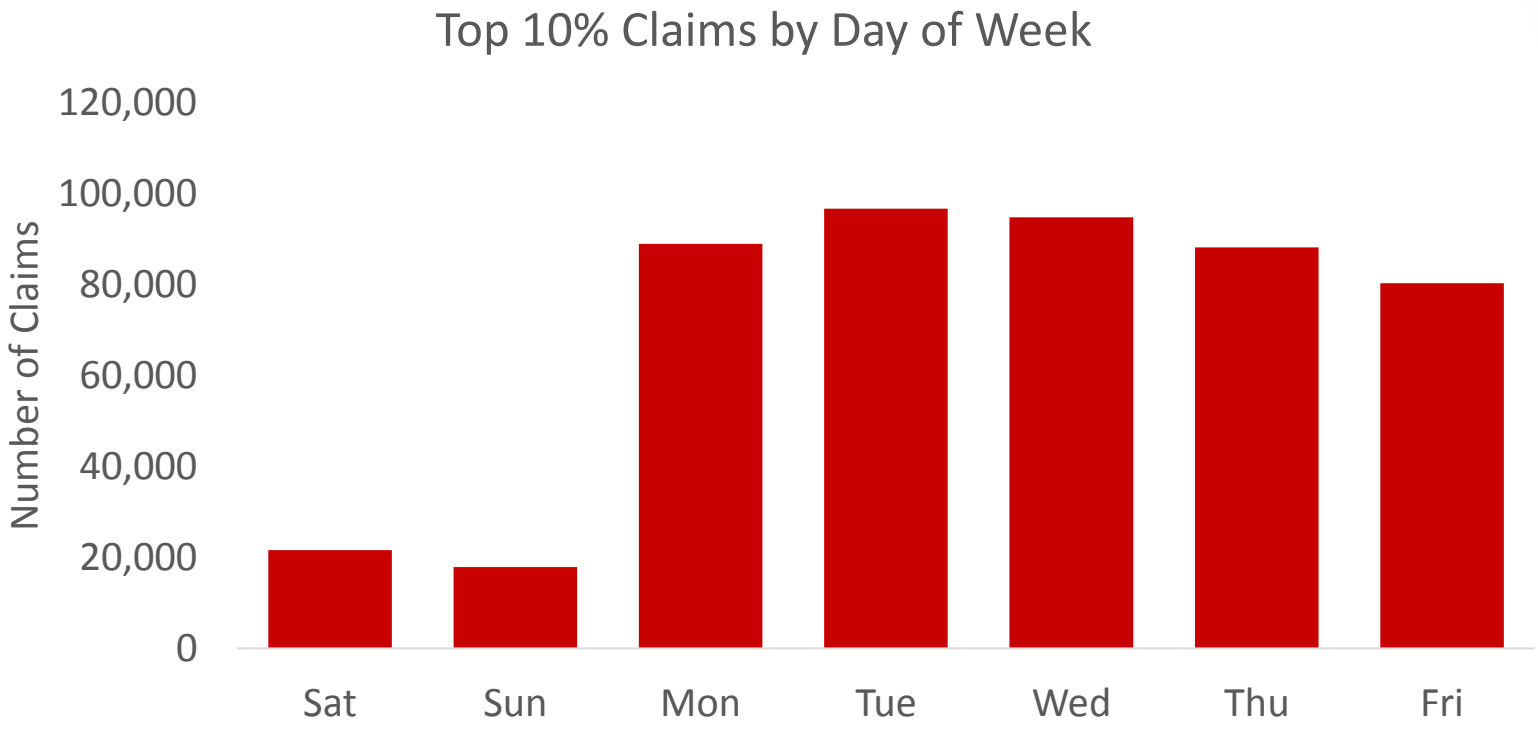
For 83% of individual days, the Top 10% had double, triple or more billing

Finding 3: Claims for The Three Codes Concentrated with Five Providers



Five Providers Accounted for 53% of Charges to the Top 10%

Finding 4: Weekdays have 4.5x as Many Claims as Weekends



Are these high-acuity behavioral cases being underserved on weekends? Or overserved on weekdays? Why the difference?

What is the Potential for Savings?

Based on Theory 1: Day Services

- To estimate, TSG projected results of the 1 million sample to the full 1.4 million claims
- The total amount for individual counseling (H0004) and group counseling (H2015) on days when H2017 is claimed is $57.8MM*
- Considering that 83% of the time we observed double or triple billing…
- If DHS had in place a policy preventing claims for H0004 or H2015 on days when H2015 is claimed, that might offer a potential for savings of $48MM

- See table, following

Summary Calculation Table

Charge Code	All Behavioral Health Claims	Results of analysis of 1 million claims for Theory 1	All Beneficiaries that Claimed H2017: Theory 1
H2017	21,058,742	*11,660,356*	
H0004	78,111,549	16,145,970	24,500,000
H2015	87,168,612	21,961,899	33,300,000
Other codes	255,722,511		
Base for Savings	**442,061,414**	**38,107,869**	**57,800,000**
Potential Savings			83%
Opportunity			**48,000,000**

Considering the Potential for Other Savings under Theories 2, 3 and 4

Theories 2-4

- Theories 2-4 look at H2015 in a school setting rather than for people receiving Day Services
- DHS paid $127.1MM* in individual counselling (H0004) and group counselling (H2015) claims above and beyond those considered in Theory 1

* Calculated amount is $105.6, See table

Considering the Wider Potential

- Of the $464MM* in Behavioral Health claims, $256MM are other than H0004, H2015 and H2017
- TSG does not yet have a basis for estimating potential for savings in these other Behavioral Health codes. However, it could be substantial

Recommended Next Steps to Size the Opportunity

TSG continue to work with DHS to further investigate to size up the opportunity and report back to the Task Force:

- Detail analysis of all of the 1.4MM claims for Theory 1
- Analysis of the School-based Theories, 2-4
- Consider what other opportunities for “same day billing” might be happening, size the opportunity for them
- Report: what is the potential for changes in policy that would reduce Behavioral Health claims

Determine the Right Mix of Solutions

- Programs:
  - Determine the extent to which providers are claiming multiple charges in order to "make due" for outdated or inappropriate Medicaid programs?
  - The Agency and providers develop new proposed services that would better meet medical needs
  - Estimate the impact of proposed changes
- Policy:
  - Determine where Medicaid lacks policy guidance by which the MMIS billing system can find and prevent "same day services"
  - Propose specific policy changes
  - Size the impact of recommended policy changes

Determine the Right Mix of Solutions

- Enforcement:
  - Determine the extent of any Waste or Abuse related to “same day services”
  - Define how Agency and OMIG can regularly find and address “same day services” claiming, where not within policy or regulations
  - Propose specific changes to Agency reporting that would enable OMIG to pursue violations of policy or regulations
- Design the “right” combination of changes to the above, revise savings estimates accordingly
- Recommend an overall path forward that generates savings AND improves Behavioral Health services

Considerations for Hospital Payment Reform

Diagnosis-Related Groups

- Reminder – Diagnosis-Related Groups (DRGs) are a hospital approach strategy for paying based on the anticipated resource costs associated with different types of patients
- The most common DRG variants are the Medicare-Severity DRG (MS-DRG) and All-Patient Refined DRG (APR-DRG)
- Differential treatment for different types of hospitals
  - Many states that use APR-DRGs for Medicaid hospital payment include children's hospitals and Critical Access Hospitals, sometimes with enhanced base rates
- Potentially different outcomes for different types of hospitals
  - High-efficiency hospitals may receive higher reimbursements through DRG-based approaches

Considerations for Hospital Payment Reform

Diagnosis-Related Groups

- Typical decision-making process
  - Legislature directs agency to develop DRG pricing methodology
  - Generally highly specialized hospital pricing consultants used to simulate effects
  - Decision to move to DRG approach should be made for policy and strategic reasons
  - Budget savings are possible
- Potential next steps
  - TSG could engage a hospital pricing consultant to initiate the process

Considerations for Hospital Payment Reform

Diagnosis-Related Groups

- Select examples of DRG variations across types of hospitals and states
  - Children's hospitals
    - California – Children's hospitals reimbursed via a DRG methodology
    - Illinois – Children's hospitals reimbursed on a prospective APR-DRG system with enhancements for certain services.
    - Virginia – Children's hospitals are reimbursed via APR-DRG with significant supplements for Disproportionate Share Hospitals and hospitals with residency programs to cover uncompensated costs.
  - Critical Access Hospitals
    - California – Includes CAHs DRG payment. Hospitals designated as remote rural get a higher base rate than non-remote rural hospitals.
    - Mississippi and South Carolina – Include CAHs within APR-DRG payment approach.

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Recommended Next Steps to Size the Opportunity

TSG can work with DHS to further investigate to size up the opportunity and report back to the TF:

- Detail analysis of all of the 1.4MM claims for Theory 1
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- Consider what other opportunities for “same day billing” might be happening, size the opportunity for them
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TSG Comparison and Comments to DiamondCare Pharmacy Recommendations

Diamond Care Pharmacy Recommendations	TSG Comparison and Comments
Expand preferred drug list and include behavioral health meds (antipsychotics)	We support expanding the PDL. If the products in a therapeutic class cannot be differentiated with evidence based comparisons, price comparisons are sufficient. We do not recommend expanding past the point of diminishing returns.
Explore multi-state prescription drug list (value based purchasing)	We support exploration of the multi-state rebate pools. DHS is already beginning to gather information on the available pools. This will allow for expanded breadth in PDL classes without a lot of effort and improved supplemental rebates in the aggregate. Rebate contracting is slowly evolving to capture some value based purchasing concepts, price inflation guarantees, clinical outcome dependent clauses, and others. This is too rigid of a contracting requirement at this time.
Give Medicaid access to prescription monitoring program	We support this recommendation and understand this change is in underway and will be evaluated in the next legislative session.
Move manual reviews by licensed psychiatrist from age 6 to 7, and eventually up to age 10 with evidence of continued cost avoidance	We support expanding manual review by licensed child psychiatrists of children to ensure drug and dose specific informed consent, metabolic monitoring and appropriate prescribing. This initiative will likely be self-funding as additional age cohorts are added.

TSG Comparison and Comments to DiamondCare Pharmacy Recommendations

Add another 100 drugs to the CAP (Competitive Acquisition Program)	**We support this recommendation and understand work to identify new drugs for the CAP program is underway at DHS.**
Remove prescription drug limits on maintenance medications	We support this recommendation and further recommend that the limits on non-maintenance medications may need to be revisited to account for this change. The first step in agreeing upon the maintenance drug list.
Include reimbursement to pharmacy for immunizations with certain criteria and referrals	For VFC, we support reimbursement to pharmacists for administration of these otherwise free vaccines. Pharmacy participation may increase if the professional administration fee is evaluated and increased. For Adult vaccinations, we recommended splitting the ingredient cost reimbursement from the professional administration fee, and reevaluating the professional fee to ensure provider program participation. We support reimbursement to pharmacists for adult vaccinations.
Explore the more transparent NADAC (National Average Drug Acquisition Cost) pricing model	We support an evaluation of current retail pharmacy reimbursement followed by a re-contracting exercise. DHS is currently conducting a CMS-required dispensing fee survey as a precursor to re-contracting. The results are expected in January. There are several national benchmarks for ingredient cost reimbursement, which include NADAC. We think DHS should have flexibility in choosing the best benchmark to meet their needs. No one reimbursement benchmark will suit all drugs or all the needs of DHS.