Alliance for Health Improvement

Mental Health Council of Arkansas

THE ALLIANCE FOR HEALTH CARE IMPROVEMENT, ARKANSAS BEHAVIORAL HEALTH PROVIDERS ASSOCIATION, AND MENTAL HEALTH COUNCIL OF ARKANSAS

all agree that the fee for service outpatient behavioral health system must be improved and revised

We support the proposal contained in the January 20, 2016 Report by The Stephen Group Report (TSG) that outlined recommendations to transform the RSPMI program to a value-based care and payment reimbursement system, including a focus on evidence-based practices and standardized outcome measures for Seriously Emotionally Disturbed (SED) children. We recommend that this should be developed through an 1115 global waiver for home and community based services.

Furthermore, in an effort to affect more immediate savings under the Medicaid Plan for RSPMI providers, we offer the following recommendations:

1. **REDEFINITION OF SERVICE ELIGIBILITY/AVAILABILITY:** We recommend that the classification for SED children be redefined. The current criteria are so broad that they unnecessarily qualify children into the category. Currently, a document is being drafted to redefine this category, so that the category will be clinically-driven, using evidence-based models of therapy with data-driven outcomes. If this action is taken, we estimate there will be a 20% reduction in the number of children meeting the criteria for SED. This reduction would result in an estimated cost savings of $ 12 million per year in the U-21 population.

2. **INDEPENDENT ASSESSMENT PROCESS TIED TO OUTCOMES MEASURES:** All provider groups are unanimous in opposing the Inter-RAI as an independent assessment tool due to the cumbersome nature of the delivery and the high cost that would be incurred by the State and the providers. We do endorse an in-depth, clinically-driven, uniform document with functional assessment components as a quality control measure for intake/diagnostic and treatment planning assessment to be utilized by all providers. The uniform document would be created by an independent third party in collaboration with provider group representatives. The assessment will be subject to independent review. For further detail, please see the attachment included.

   Utilization of such a process will create no additional expense to the Medicaid Program for data or process purchases. The result is the State avoiding the expenditure of $ 6 million per year resulting in a $ 30 million savings or over 5 years for assessment teams with appropriate credentials as well as the avoidance of delays in access to care.

3. **CAPITATED RATE ASSIGNMENTS:** We support the 2 unit reduction in daily limits from 8 units to 6 units for MHP Interventions and MHPP Interventions for those individuals receiving services designated under the SED and SMI categories. We estimate that the 2 unit reduction would save $ 9.5 million.

4. **REORGANIZATION OF SCHOOL BASED SERVICES:** We propose to organize school based/school related/school linked RSPMI services into a two level system based on assessment, resource utilization, and level of acuity. (This process will be integrated into the proposed intake assessment.) The leveled system would include school linked services such as after-school programs and summer programs. This change will need to occur in phases to ensure continuity of care and transition to appropriate levels of care. We estimate that with the coupling of the redefinition of SED that there will be a minimum of a 20% reduction of service need/provision realized with the leveled system of assigning services. This reduction is estimated to be $ 6 million per year.

5. **CAPITATED RATE ASSIGNMENTS:** Based on current available data, we suggest a unit reduction in the daily limit for Group Therapy be applied to the traditional outpatient services, excluding rehabilitative day services and therapeutic acute day services in day treatment settings. This 2 unit reduction would save a potential amount of $ 4.8 million per year. We can derive a more precise calculation upon further review of the data.

6. **DOCUMENTATION REDUCTION:** All provider groups endorse reducing the review of Treatment Plans from every 90 days (3 months) to twice yearly (every 6 months). No other third party payer requires Treatment Plan Reviews every 90 days. We estimate that $ 4 million per year could be saved from this reduction in Treatment Plan Reviews.

7. **PROTECTION OF DCFS/DYS CASES:** We recommend exempting children served by the Division of Children and Family Services (DCFS) and Division of Youth Services (DYS) from any cuts or reductions in behavioral health services due to the State's responsibility to meet the needs of this vulnerable population. We would support the development of a program specifically tailored to this group that would meet the high level needs of the children while at the same time provide alternative funding. DCFS currently spends approximately $ 3.6 million in State general revenue purchasing acute, subacute, and SRP behavioral health services for children served by DCFS. This is not covered by Medicaid because the services are provided to children who are not in full custody, or the services do not meet current programmatic requirements. A need for lower levels of care not currently available and the lack of appropriate services outside an acute setting could be addressed through an 1115 demonstration waiver. By providing Medicaid-eligible services to this group, those State funds could be used to draw down Medicaid federal financial participation dollars, resulting in the ability to purchase the same services for $ 1.8 million. By leveraging the 70% federal match rate on those behavioral health services being purchased by DCFS, the State would realize an additional $ 2.52 million per year in State general revenue.

   It is also possible to realize additional savings from other programs such as DYS After-Care, whose figures are unavailable at this time.

8. **ELIMINATION OF UNNECESSARY SERVICE:** We propose that the Medicaid requirement for annual continued care Psychiatric Diagnostic Assessment (PDA) be eliminated. The rationale follows that psychiatric time is at a premium. Also, Pediatricians/Primary Care Physicians (PCPs) have assessed the children upon referral. Furthermore, for those clients not receiving psychotropic drugs, the service is unnecessary for treatment and only serves to fulfill a requirement for payment. If a client is being seen for medication management, then the physician is already routinely seeing the child meaning this requirement is purely an additional cost. We estimate $ 1 million per year will be saved by this adjustment.

9. **CARE COORDINATION:** We believe that care coordination is paramount to the successful management of clients' needs. We support replacing collateral intervention services, with a "care coordination" service available only for SED/Serious Mental Illness (SMI) cases to significantly improve care and decrease cost. This cost shifting and repurposing of care services does not have an estimated savings at this time.

10. **ELIMINATION OF RSPMI BILLING IN COMMUNITY SUPPORT PROGRAMS:** As an additional cost reduction and containment measure, if the processes proposed above are implemented, then we support the development of a per diem rate for therapeutic community programs for persons with SMI requiring 24 hour psychiatric clinical support to include daily program service resources and treatments. With suggested per diem rates of $ 200 - $ 280, the cost savings are estimated to be $ 2 million or more per year. This payment realignment will eliminate clients in these specialized therapeutic community programs from receiving multiple, authorized services on the same day.

    This is in addition to the savings realized from avoiding using more costly levels of care. This adjustment would require a tiered payment rate allowing for the varying programming needs. For example, this includes those clients being discharged from Arkansas State Hospital (ASH) or those at an imminent risk of community psychiatric hospitalization with referral to ASH. This adjustment could even be used as a step-down for clients transitioning from a community psychiatric hospital, but continue to need a highly structured environment, including 24 hour supervision and treatment to successfully transition back into the community.

11. **INCREASE ACCESS TO CARE:** We support a proposal to redesign professional licensure credentialing requirements of the Private Option (PO) program to match the Medicaid requirements, so that PO beneficiaries could be accommodated with services commensurate with the Medicaid program. In doing this, access to care will be improved for those covered by the PO, and it will assist in service availability for clients in the prison reform re-entry program, diversion programs, and substance abuse treatment programs.

12. **INCREASE ACCESS TO CARE:** We support a change in the Medicaid payment system to allow Advanced Practice Registered Nurses with prescriptive authority (APRN) to provide services via telemedicine as physicians are allowed to provide. The availability of this practice will increase patients' access to care.

13. **COST REFINEMENT:** TSG attributed $ 65,348,908 in spending to the Individual Speech Therapy Code 92507 in the "Behavioral Health Charged Codes" Chart earlier this month (page 4 of the January 20, 2016 report). We recommend reducing that service by 95% - 100% to realize RSPMI savings.

An additional option to consider is eliminating the annual cost settlement practice of providing additional funds to certain RSPMI programs in the amount of $ 6 - 8 million per year. This will reduce annual costs in the overall program by the settlement amount. This practice creates unnecessary costs to the program without the benefit of funding any additional services. It also creates an inequitable financial disparity in that it is applied to a few providers that receive the cost settlements in an otherwise non-cost-based program.

Behavioral Health Group

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ARHPA

State Fiscal Year 2014 Comparison

Behavioral Health Group Totals		
Code	Description	SFY 2014 Total
90847	Family Medial Psychotherapy with the Patient Present	$13,499,280.14
90853	Group Outpatient - Group Psychotherapy	$46,167,196.64
90885	Psychiatric Examination of Records	$14,117,194.79
90887	Interpretation or Explanation of Results of Psychiatric	$15,175,191.03
99213	Established Patient Office or Other Outpatient, Visit Typically 15 Minutes	$2,582,886.79
99214	Established Patient Office or Other Outpatient, Visit Typically 25 Minutes	$1,894,110.94
H0004	Behavioral Health Counseling & Therapy, Per 15 Minutes	$73,351,308.43
H2015	Intervention, Mental Health Paraprofessional	$85,619,247.27
H2017	Rehabilitative Day Service	$21,183,377.61
Other	All other BH Procedure Codes	$27,753,139.64
	Grand Total	$303,542,933.28

The Stephen Group Totals		
Code	Description	SFY 2014 Total
90847	Family Medial Psychotherapy with the Patient Present	$13,860,035.00
90853	Group Outpatient - Group Psychotherapy	$51,079,618.00
90885	Psychiatric Examination of Records	$14,139,721.00
90887	Interpretation or Explanation of Results of Psychiatric	$15,805,678.00
99213	Established Patient Office or Other Outpatient, Visit Typically 15 Minutes	$33,739,081.00
99214	Established Patient Office or Other Outpatient, Visit Typically 25 Minutes	$29,204,758.00
H0004	Behavioral Health Counseling & Therapy, Per 15 Minutes	$78,111,549.00
H2015	Intervention, Mental Health Paraprofessional	$87,168,612.00
H2017	Rehabilitative Day Service	$21,058,742.00
Other	All other BH Procedure Codes	$55,169,807.00
	Grand Total	$399,337,601.00

State Fiscal Year	Total of All BH Procedure Codes	Average Cost per Mental Health Provider
2013	$297,355,424.16	$5,718,373.54
2014	$303,542,933.28	$5,837,364.10
2015	$300,221,619.18	$5,773,492.68

The total per year was calculated by taking the grand total and subtracting procedure codes 92507 & 92508.

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Projected Cost Savings

	RSPMI - Projected Cost Savings	
1	Redefining SED	$12 million
2	Independent Assessment - Universal Assessment	
3	Unit reduction on Intervention (from 8 to 6) (Procedure Code - H2015)	$9.5 million
4	School based service with two level system based	$6 million
5	Group therapy unit reduction by 2 - exception included (Procedure Code - 90853)	$4.8 million
6	Treatment plan - Twice yearly. (Procedure Code - 90885)	$4 million
7	Foster Children - New Level of care	
8	Elimination of annual psychiatric evaluation (Procedure Code 90792)	$1 million
9	Introduction of Care Coordination	
10	Develop & Implement per diem for seriously Mentally Ill	$2 million
11	Redesign the credential requirement for PO coverage - Access to care	
12	Include APRN with Psychiatric Certification	
13	Remove speech therapy	
	Total Projected Savings	$39.3 million

Our calculation of cost savings was based on the following information:

- Total clients served under outpatient Mental Health Services - 75,000
- Adult clients served- 40%
- Children clients served- 60%
- Data used was obtained from the DSS lab of DHS for the following periods - SFY 2013, SFY 2014, & SFY2015
- SFY 2014 Expenditures was utilized for the cost savings calculation

RECOMMENDATION FOR INDEPENDENT ASSESSMENT FOR RSPMI SERVICES

- All provider groups are unanimous in opposing the Inter-RAI as an independent assessment tool due to the cumbersome nature of the delivery and the high cost that would be incurred by the state and the providers.

- We do endorse an in-depth clinically driven uniform document with functional assessment components as a quality control measure for intake/diagnostic and a treatment planning assessment utilized by all providers. This instrument is proposed to be developed by a third party in collaboration with provider groups.

- This assessment would be subject to desk review by trained intake peer assessors (from a non stakeholder company) following the established model set by substance abuse treatment providers.

- We recommend these assessments be kept by the provider entrusted to provide care for the individual so a random sampling of cases can also be performed at site inspections by the state contracted organization as scheduled.

- Non-SED/SMI cases will not be subject to this desk review due to the limited service package available for this population.

- We propose a pilot project be implemented for at least one year at which time a determination be made as to whether it continues or is replaced with a more costly alternative.

- Utilization of such a process would be negotiated with providers to be at a low cost to cost neutral.

- There would be no additional expense to the Medicaid Program for data or process purchases realizing a savings of the purchase price.