Arkansas Payment Improvement Initiative (APIII)

ADHD Supplemental Report
Statewide Webinar
November 20, 2013
Building a healthier future for all Arkansans

- Lee Clark, Medicaid Health Innovation Unit Episodes Manager - Overview of the Healthcare Payment Improvement Initiative

- Shelley Tounzen, Medicaid Health Innovation Unit Public Information Coordinator – Initiative Update

- Patricia Gann, Value Options Program Director - ADHD Supplemental Report
Today, we face major health care challenges in Arkansas

- The health status of Arkansans is poor: the state is ranked at or near the bottom of all states on national health indicators, such as heart disease and diabetes

- The health care system is hard for patients to navigate, and it does not reward providers who work as a team to coordinate care for patients

- Health care spending is growing unsustainably:
  - Insurance premiums doubled for employers and families in past 10 years (adding to uninsured population)
  - Large projected budget shortfalls for Medicaid
Our vision to improve care for Arkansas is a comprehensive, patient-centered delivery system

**For patients**
- Improve the health of the population
- Enhance the patient experience of care
- Enable patients to take an active role in their care

**For providers**
- Reward providers for high quality, efficient care
- Reduce or control the cost of care

**How care is delivered**

**Population-based care**
- Medical homes
- Health homes

**Episode-based care**
- Acute, post-acute, or select chronic conditions

**Four aspects of broader program**
- Results-based payment and reporting
- Health care workforce development
- Health information technology (HIT) adoption
- Consumer engagement and personal responsibility

Focus today
Medicaid and private insurers believe paying for results, not just individual services, is the best option to improve quality and control costs.

<table>
<thead>
<tr>
<th>Initiative Aims To…</th>
<th>Transition to a payment system that <strong>rewards value and patient health outcomes</strong> by aligning financial incentives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>✔️</strong> Reduce payment levels for all providers** regardless of their quality of care or efficiency in managing costs**</td>
<td></td>
</tr>
<tr>
<td><strong>✗</strong> <strong>Pass growing costs on to consumers</strong> through higher premiums, deductibles and co-pays (private payers), or higher taxes (Medicaid)</td>
<td></td>
</tr>
<tr>
<td><strong>✗</strong> Intensify payer intervention in decisions though managed care or elimination of** expensive services (e.g. through prior authorizations) based on restrictive guidelines</td>
<td></td>
</tr>
<tr>
<td><strong>✗</strong> Eliminate coverage of** expensive services or eligibility**</td>
<td></td>
</tr>
</tbody>
</table>

This initiative **DOES NOT** aim to
Principles of payment design for Arkansas

- **Patient-centered**: Focus on improving quality, patient experience and cost efficiency
- **Clinically appropriate**: Design based on evidence, with close input from Arkansas patients and providers
- **Practical**: Consider scope and complexity of implementation
- **Data-based**: Make design decisions based on facts and data
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Arkansas Health Care Payment Improvement Initiative
Provider Report

Medicaid
ADHD supplement
Report date: October 2013
Provider: Dr. Jane Doe

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Division of Medical Services
P.O. Box 1437, Slot S-415 - Little Rock, AR 72203-1437

Dear Medicaid Provider:

Medicaid appreciates the feedback received on the ADHD reports. This supplemental report is intended to address the requests for more information on the episodes in the first payment period. The episodes in this supplemental report are limited to those that started between Oct 1, 2012, and Dec 31, 2012. These episodes, which will close between Oct 1, 2013 and Dec 31, 2013, will have their payment-related report in April 2014. This supplemental report covers both included and excluded episodes and their costs. Below is a description of the supplemental report contents.

Overview section: This section lists the number of episodes that started in the current performance period (Oct 1, 2012 – Dec 31, 2012), the number that are Level I severity, Level II severity, and those that are currently being excluded due to one or more exclusion criteria. It also includes estimates of your annualized average episode cost and estimated gain-sharing or risk-sharing. The estimated annualized average episode cost is based on your claims included to date and the average amount of time since each of your ADHD episodes started. This number is only an estimate, and should be expected to change as claims are filed over time. The estimated gain-sharing or risk-sharing is calculated by comparing your estimated average episode cost to the acceptable and commendable thresholds. GAIN AND RISK SHARING ESTIMATES ARE APPROXIMATE VALUES. THESE WILL BE SUBJECT TO CHANGE AS ADDITIONAL CLAIMS ARE FILED. IN PARTICULAR, ANY ESTIMATED RISK-SHARING AMOUNT, IF PRESENT, DOES NOT FACTOR IN ANY STOP LOSS PROVISIONS.

Cost section: This section is designed to give providers an overview of spending on these episodes. The upper pair of graphs show a time series view of average episode spend for Level I and Level II episodes. It also reflects the acceptable and commendable thresholds for these episodes. The average cost for your episodes is shown by the solid black line. The point at the end of the dashed line shows the annualized episode cost. This calculation may help you estimate episode average costs at the end of the performance period. The table below shows the dates of service included in the calculation of average episode cost at each data point on the graph. Each subsequent point on the graph incorporates one additional quarter of claims. There is allowance for three months of claims run-out. Again, these claims come only from episodes that started in the period from 10/1/2012 to 12/31/2012.

<table>
<thead>
<tr>
<th>Graph data points</th>
<th>Episode start dates</th>
<th>Date of service range from 10/1/2012 to:</th>
<th>Last day of report claims run-out period</th>
</tr>
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<tbody>
<tr>
<td>Dec 2012</td>
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<tr>
<td>Mar 2013</td>
<td>3/31/2013</td>
<td>6/30/2013</td>
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<tr>
<td>Jun 2013</td>
<td>6/30/2013</td>
<td>9/30/2013</td>
<td></td>
</tr>
<tr>
<td>Sep 2013</td>
<td>9/30/2013</td>
<td>12/31/2013 Data not yet available due to run-out</td>
<td></td>
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<tr>
<td>Dec 2013</td>
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<tr>
<td>Computed annualized cost</td>
<td>Computed annualized cost</td>
<td>Computed annualized cost</td>
<td></td>
</tr>
</tbody>
</table>
The lower graphic displays your average cost for the current period compared to the average cost for all PAPs.

**Exclusion section:** This section reflects episodes that are currently excluded from the main report and the reason why they do not meet criteria for an ADHD episode. (Some excluded episodes may not be excluded in future periods, as for example, minimum care standards are met.) Exhibit 3 identifies the percentage of episodes that have been excluded. A second graph then breaks down excluded episodes by the specific exclusion. The number of exclusions may not equal the number of excluded episodes because it is possible for one episode to have multiple exclusions. Exhibit 4 describes each of the potential exclusions.

**Detail section:**
There are four sections in the detailed report.
1. ADHD beneficiaries potentially excluded from episode: Applicable Exclusions
   In this report every excluded beneficiary is shown with their specific exclusions marked with a Y/N. A “Y” indicates that the patient was excluded for the reason listed in the respective column. Any episode may have more than one reason for exclusion, and may therefore have more than one “Y”. Again, if an episode has been excluded, it may still be included in future reports. For example, if an episode has been excluded due to falling below the minimum cost threshold there is potential for this episode to be included in future reports if spending on the beneficiary increases later in the performance period.
2. ADHD beneficiaries potentially excluded from episode: Cost Breakdown
   This report shows the episode cost associated with each patient that is currently excluded from the episodes.
3. Detailed ADHD Level I open episode cost information
   This report shows a breakdown of costs for currently open Level I episodes. Costs and claim count are broken out by care category. The quality metric data is not available for this supplemental report.
4. Detailed ADHD Level II open episode cost information
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This supplemental report is a result of provider feedback. Please continue to keep us informed about how we can best support providers in delivering high-quality cost-effective care. We also have made available answers to frequently asked questions on our website at www.paymentinitiative.org. For items not addressed here, you can call our helpdesk at either 1-866-322-4656 or 501-301-8311(locally). You may also email ARKPH@hp.com.

Sincerely,

Andy Allison, PhD
Medicaid Director

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- Performance summary
- April 2014 payment open episodes
  - Attention Deficit/Hyperactivity Disorder (ADHD) Level I and II
- April 2014 payment open episodes
  - Attention Deficit/Hyperactivity Disorder (ADHD) Exclusions
- Appendix: Episode level detail
Summary – ADHD: April 2014 payment open episodes

1 Overview

Total episodes: 266  Level I included episodes: 9  Level II included episodes: 0  Total episodes excluded: 257

Estimated annualized average cost:
Level I: $4,521
Level II: N/A

Estimated gain- or risk-sharing:
Level I: $10,342 of risk sharing
Level II: N/A

Total estimated gain/risk share: $10,342 of risk sharing

2 Cost graphics

Average episode cost time series
USD, service dates from 10/1/2013 to end of month given in graph

Level I

Average episode cost vs others'
USD, service dates from 10/1/2012 to 6/30/2013

Level I

Level II
ADHD beneficiary breakdown – April 2014 payment

3 Potential exclusions for in-progress episodes

Current status of episode validity

<table>
<thead>
<tr>
<th>Status</th>
<th>Percentage</th>
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Count of exclusion categories

<table>
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<th>Category</th>
<th>Count</th>
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<tr>
<td>Third party liability</td>
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<td>Minimum care</td>
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<td>Co-morbidity</td>
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<td>PAP Attribution</td>
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<tr>
<td>High outlier</td>
<td>6</td>
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<tr>
<td>Incomplete episode</td>
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</tbody>
</table>

1 Final episode inclusion and exclusion is finalized after the end of the performance period. Until then, status of valid episode validity is subject to change as more information is collected.

2 Exclusions are not mutually exclusive.

4 Exclusion definitions

- **Continuous coverage**: Beneficiary must be covered by Medicaid for duration of the episode and must not have other insurance.
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- **Co-morbidity**: Beneficiaries with certain behavioral health comorbidities should not be captured by this episode.
- **PAP Attribution**: The provider has not provided a sufficient amount of the ADHD services to qualify as a PAP.
- **High outlier**: Episodes where treatment costs are extreme. These are excluded from average cost calculations as they may not be appropriately addressed by the episode structure.
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Medicaid
ADHD supplement
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</tr>
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<tr>
<td>Attention Deficit/Hyperactivity Disorder (ADHD) Exclusions</td>
</tr>
<tr>
<td>Appendix: Episode level detail</td>
</tr>
</tbody>
</table>
Summary – ADHD: April 2014 payment open episodes

1 | Overview

Total episodes: 11  
Level I included episodes: 5  
Level II included episodes: 1  
Total episodes excluded: 5

Estimated annualized average cost:
Level 1: $2,064  
Level 2: $3,520

Estimated gain- or risk-sharing
Level 1: $0  
Level 2: $941 of gain sharing

Total estimated gain/risk share: $941 of gain sharing

2 | Cost graphics

Average episode cost time series
USD, service dates from 10/1/2013 to end of month given in graph

Level I

Level II

Average episode cost vs others*
USD, service dates from 10/1/2012 to 6/30/2013

Level I

Level II
ADHD beneficiary breakdown – April 2014 payment

3 | Potential exclusions for in-progress episodes

Current status of episode validity

<table>
<thead>
<tr>
<th>Status</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Currently Valid</td>
<td>45%</td>
</tr>
<tr>
<td>Valid</td>
<td>55%</td>
</tr>
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</table>

Count of exclusion categories

<table>
<thead>
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<th>Category</th>
<th>Count</th>
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</thead>
<tbody>
<tr>
<td>Continuous covg.</td>
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<tr>
<td>Third party liability</td>
<td>0</td>
</tr>
<tr>
<td>Minimum care</td>
<td>5</td>
</tr>
<tr>
<td>Co-morbidity</td>
<td>2</td>
</tr>
<tr>
<td>PAP Attribution</td>
<td>4</td>
</tr>
<tr>
<td>High outlier</td>
<td>0</td>
</tr>
<tr>
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**Incomplete episode**
Episodes where treatment costs are too low. These are excluded from average cost calculations as there may be claims for the episode that have not yet been submitted.
## ADHD beneficiaries potentially excluded from episode, applicable exclusions

<table>
<thead>
<tr>
<th>Episode ID</th>
<th>Patient name</th>
<th>Quality standard achieved</th>
<th>Episode start &amp; end date</th>
<th>Non-adjusted cost</th>
<th>Cost</th>
<th>Exclusions (Y means the beneficiary was excluded for this reason)</th>
<th>PAP attribution</th>
<th>High outlier</th>
<th>Incomplete episode</th>
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### ADHD beneficiaries potentially excluded from episode, cost breakdown

<table>
<thead>
<tr>
<th>Episode ID</th>
<th>Patient name</th>
<th>Quality standard achieved</th>
<th>Episode start &amp; end date</th>
<th>Non-adjusted cost</th>
<th>Cost</th>
<th>Care categories with costs [cost / # of claims]</th>
<th>Outpatient professional</th>
<th>Pharmacy</th>
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</table>
## Detailed ADHD Level I open episode cost information

<table>
<thead>
<tr>
<th>Episode ID</th>
<th>Patient name</th>
<th>Quality standard achieved</th>
<th>Episode start &amp; end date</th>
<th>Non-adjusted cost</th>
<th>Cost</th>
<th>Care categories with costs [cost / # of claims]</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
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<td>Outpatient professional Pharmacy Emergency department Outpatient lab Outpatient radiology / procedures Inpatient professional Inpatient facility Outpatient surgery Other</td>
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## Detailed ADHD Level II open episode cost information

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<th>Cost</th>
<th>Outpatient professional</th>
<th>Pharmacy</th>
<th>Emergency department</th>
<th>Outpatient lab</th>
<th>Outpatient radiology / procedures</th>
<th>Inpatient professional</th>
<th>Inpatient facility</th>
<th>Outpatient surgery</th>
<th>Other</th>
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Questions
For more information talk with provider support representatives…

**Online**

- More information on the Payment Improvement Initiative can be found at [www.paymentinitiative.org](http://www.paymentinitiative.org)
  - Further detail on the initiative, PAP and portal
  - Printable flyers for bulletin boards, staff offices, etc.
  - Specific details on all episodes
  - Contact information for each payer’s support staff
  - All previous workgroup materials

**Phone/ email**

- **Medicaid**: 1-866-322-4696 (in-state) or 1-501-301-8311 (local and out-of state) or [ARKPII@hp.com](mailto:ARKPII@hp.com)

- **Blue Cross Blue Shield**: Providers 1-800-827-4814, direct to EBI 1-888-800-3283, [APIICustomerSupport@arkbluecross.com](mailto:APIICustomerSupport@arkbluecross.com)

- **QualChoice**: 1-501-228-7111, providerrelations@qualchoice.com