Arkansas Payment Improvement Initiative (APII)

Oppositional Defiant Disorder
Statewide Webinar
October 21, 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

- Laurence H. Miller, Senior Psychiatrist for Division of Medical Services – ODD Episode Description

- Patricia Gann, Value Options Program Director - Episode Certifications and Portal

- Paula Miller, HP Research Analyst - Episode Design and Reports
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

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

This initiative aims to...

- Transition to a payment system that **rewards value and patient health outcomes** by aligning financial incentives

This initiative **DOES NOT** aim to...

- Reduce payment levels for all providers regardless of their quality of care or efficiency in managing costs
- Pass growing costs on to consumers through higher premiums, deductibles and co-pays (private payers), or higher taxes (Medicaid)
- Intensify payer intervention in decisions though managed care or elimination of expensive services (e.g. through prior authorizations) based on restrictive guidelines
- Eliminate coverage of expensive services or eligibility
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
Building a healthier future for all Arkansans

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In Arkansas, clients aged 6-17 account for 90%+ of non-comorbid clients and spend

Episodes¹ ending in SFY 2011 (i.e., one year data), Medicaid only (N=10,477)

<table>
<thead>
<tr>
<th>Breakdown of 3-month episodes with at least one ODD¹ claim</th>
<th>ODD-only episodes by age group²</th>
<th>ODD-only episode spend by age group²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thousands of 3-month episodes</td>
<td>Percentage</td>
<td>Percentage</td>
</tr>
<tr>
<td>Only one ODD claim</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>ODD episodes with a comorbid BH condition³</td>
<td>41%</td>
<td>42%</td>
</tr>
<tr>
<td>ODD-only episodes with &gt;1 claim</td>
<td>59%</td>
<td>58%</td>
</tr>
<tr>
<td>Total episodes With any ODD claim</td>
<td>~9.5k</td>
<td>$19 million</td>
</tr>
</tbody>
</table>

1 ODD episode defined as three month treatment program with at least 2 claims with primary diagnosis of ICD-9 code 31381
2 Pre-school = 0 – 5 years of age; School-aged = 6 – 11 years of age; Adolescent = 12 – 17 years of age; Adult = greater than 18 years of age
3 Comorbid conditions defined as any other behavioral health ICD-9 codes diagnosis with two claims during course of three months

SOURCE: Arkansas Department of Human Services (DHS), Division of Medical Services SFY2011 Claims data (includes pharmacy)
In Arkansas, clients aged 6-17 account for 90%+ of non-comorbid clients and spend

Episodes ending in SFY 2011 (i.e., one year data), Medicaid only (N = 10,477)

Breakdown of 3-month episodes with at least one ODD claim

<table>
<thead>
<tr>
<th>Description</th>
<th>Thousands of 3-month episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only one ODD claim</td>
<td>0.5</td>
</tr>
<tr>
<td>ODD episodes with a comorbid BH condition</td>
<td>4.6</td>
</tr>
<tr>
<td>ODD-only episodes with &gt;1 claim</td>
<td>11.2</td>
</tr>
<tr>
<td>Total episodes With any ODD claim</td>
<td>16.3</td>
</tr>
</tbody>
</table>

| ODD-only episodes by age group² |
|-------------------------------|-------------------------------|
| Percentage                    | Percentage                    |
| Preschool                     | School-aged                   |
| 100%                          | 100%                          |
| 6%                            | 37%                           |
| 39%                           | 53%                           |
| 2%                            | 4%                            |
| 53%                           | 53%                           |

1 ODD episode defined as three month treatment program with at least 2 claims with primary diagnosis of ICD-9 code 31381
2 Pre-school = 0 – 5 years of age; School-aged = 6 – 11 years of age; Adolescent = 12 – 17 years of age; Adult = greater than 18 years of age
3 Comorbid conditions defined as any other behavioral health ICD-9 codes diagnosis with two claims during course of three months

SOURCE: Arkansas Department of Human Services (DHS), Division of Medical Services SFY2011 Claims data (includes pharmacy)
Distribution of number of non-comorbid ODD clients treated by individual providers

Episodes ending in SFY 2010 – SFY 2011 (i.e., two years of data), Medicaid only

Number of clients treated by individual providers (clients aged 6 – 17, no comorbid conditions)¹ (N=9,418)

<table>
<thead>
<tr>
<th>Provider count</th>
<th>1-5</th>
<th>6-10</th>
<th>11-20</th>
<th>21-50</th>
<th>51-100</th>
<th>101+</th>
</tr>
</thead>
<tbody>
<tr>
<td># clients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of Providers</td>
<td>54%</td>
<td>9%</td>
<td>12%</td>
<td>13%</td>
<td>7%</td>
<td>5%</td>
</tr>
<tr>
<td>% of Episodes</td>
<td>0.8%</td>
<td>2.4%</td>
<td>6.1%</td>
<td>18.1%</td>
<td>26.5%</td>
<td>46.0%</td>
</tr>
<tr>
<td>Average episodes per client¹</td>
<td>1.2</td>
<td>1.6</td>
<td>2.0</td>
<td>2.3</td>
<td>2.6</td>
<td>2.5</td>
</tr>
</tbody>
</table>

¹ Episode defined as one 90 day program

SOURCE: Arkansas Department of Human Services (DHS), Division of Medical Services SFY2010-SFY2011 Claims data (includes pharmacy)
Concordant with evidence-based programs, the most frequent services provided are non-medical interventions

Episodes ending in SFY 2011 (i.e., one year data), Medicaid only

Cost breakdown by service type for ODD episodes (clients aged 6 – 17, no comorbid conditions) (N=9,418), Total cost, ($ millions)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Cost</th>
<th>% Total Cost</th>
<th>% Episodes with Occurrence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>$19 M</td>
<td>5%</td>
<td>69%</td>
</tr>
<tr>
<td>Assessment</td>
<td>$1 M</td>
<td>6%</td>
<td>17%</td>
</tr>
<tr>
<td>Testing</td>
<td>$1 M</td>
<td>11%</td>
<td>78%</td>
</tr>
<tr>
<td>Office visits</td>
<td>$2 M</td>
<td>68%</td>
<td>92%</td>
</tr>
<tr>
<td>Non-medication interventions</td>
<td>$13 M</td>
<td>9%</td>
<td>39%</td>
</tr>
<tr>
<td>Medication</td>
<td>$2 M</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 Represents assessments billed to Medicaid. 58% of spend is from 90885 9 ZZZ, Psychiatric evaluation of hospital records; 42% of spend from 90801 9 ZZZ Psychiatric diagnostic interview exam
2 90% of spend from uncoded claims (no CPT code); 5% of spend from 90801 9 AR1, Psychological testing; 4% of spend from 96101 9 ZZZ, Psychological testing (includes psychodiagnostic tests of emotion); 1% other
3 Non-medication interventions includes all psychotherapy, counseling, community support, and therapeutic activities

SOURCE: Arkansas Department of Human Services (DHS), Division of Medical Services; Arkansas Department of Human Services (DHS), Division of Medical Services SFY2011 Claims data (includes pharmacy)
### Behavioral Health Providers provide the vast majority of ODD care in Arkansas

Episodes ending in SFY 2011 (i.e., one year data), Medicaid only

<table>
<thead>
<tr>
<th>Cost breakdown by provider for ODD episodes (clients aged 6 – 17, no comorbid conditions) (N=9,418)</th>
<th>Total cost, ($ millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>$19M</td>
</tr>
<tr>
<td>Physician (PCP or Psychiatrist)</td>
<td>$18.5M</td>
</tr>
<tr>
<td>Other¹</td>
<td>$0.1M</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Episode count</th>
<th>% total episodes</th>
<th>Average cost / episode</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>190</td>
<td>$1,311</td>
</tr>
<tr>
<td><strong>Physician (PCP or Psychiatrist)</strong></td>
<td>10,225</td>
<td>$1,782</td>
</tr>
<tr>
<td><strong>Behavioral health provider organization</strong></td>
<td>62</td>
<td>$731</td>
</tr>
</tbody>
</table>

¹ Other includes FQHC providers, non-behavioral health provider school-based providers, and non-standard providers of care

**SOURCE:** Arkansas Department of Human Services (DHS), Division of Medical Services SFY2011 Claims data (includes pharmacy)
A third of clients (32%) are receiving care above and beyond what is recommended in guidelines and evidence-based treatments

Episodes ending in SFY 2010 – SFY 2011 (i.e., two years of data), Medicaid only

Estimated cost of effective evidence based programs

These clients represent 63% of spend

Episodes cost distribution for episodes (clients aged 6 – 17, no comorbid conditions)

Average cost / episode ($)
Guideline-concordant treatment pathway for clients diagnosed with ODD

<table>
<thead>
<tr>
<th>Assessment &amp; Diagnosis</th>
<th>Treatment</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| ▪ Thorough assessment is performed | ▪ Initial treatment plan\(^1\): **2 visits per week\(^2\) for 12 weeks** (based on evidence based programs)  
  - ~40% improve\(^3\)  
  - Re-assess those that do not improve | ▪ Effectiveness of treatment |
| ▪ Licensed clinician confirms diagnosis and is responsible for care | ▪ Second treatment plan\(^1\): **2 visits per week\(^2\) for 12 weeks** (based on evidence based programs)  
  - ~30% improve\(^3\)  
  - Re-assess those that do not improve | ▪ Reasons necessitating second treatment plan |
| ▪ Parent/caregiver notification | | ▪ Continuing care |

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\(^1\) Evidence Based Psychosocial Treatments for Children and Adolescents with Disruptive Behavior; 2 Visits may include client or parent/caregiver therapy; 3 Expert Interviews

ODD episode is 90-days, with single severity level, and a single certification at the beginning of each episode

Assessment of new client

‘Quality assessment’ certification

90 day Episode

Clients included
- ODD-only; no BH comorbid conditions

Treatment
- 1-2 visits/week
- Behavioral therapy or psychotherapy
- Parent/teacher behavior support

Thresholds for episode

‘Continuing care’ certification

Client Remission

Episode recurrence

Submitted on Provider Portal

1 Parent/Teacher Behavior support includes education via books, videos, or a one-time series of in-person training sessions
DSM criteria for ODD (to be used with ‘Quality Assessment’ certification)

### Description

**A**  
At least four symptoms from any of the following categories over a 6 month period at least weekly (if age over 5) or almost daily (under 5)

<table>
<thead>
<tr>
<th>Angry/irritable mood</th>
<th>Argumentative/Defiant behavior</th>
<th>Vindictiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Loses temper</td>
<td>▪ Argues with authority figures/adults</td>
<td>▪ Has been spiteful/vindictive twice in 6 months</td>
</tr>
<tr>
<td>▪ Is touchy or easily annoyed</td>
<td>▪ Actively defies or refuses to comply with requests from authority figures or rules</td>
<td></td>
</tr>
<tr>
<td>▪ Is angry and resentful</td>
<td>▪ Deliberately annoys others</td>
<td></td>
</tr>
<tr>
<td>▪ Blames others for mistakes/misbehavior</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**B**  
Symptoms must cause clinically significant impairment in social, educational, or vocational activities

**C**  
Disturbance is not solely due to another diagnosis (e.g., psychotic, substance abuse, or depressive)

**D**  
Criteria are not met for Conduct Disorder, and, if the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder

SOURCE: APA changes for DSM-V, 2013
Eligible to serve as PAP

*Providers will bill their claims in the same manner as today*

- **Primary care physicians**
  - Pediatricians, Family Practice physicians
- **Psychiatrists**
  - Individual practice or within Behavioral health provider organizations
- **Licensed clinical psychologists in individual practice**¹
  - Ph.D. or Psy.D training; licensed according to state requirements
- **Behavioral health provider organization**
  - The Behavioral health billing organization will be the Principal Accountable Provider

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Eligible to provide care, but not to serve as PAP

*All providers currently eligible to provide care will be eligible under the episode model and will bill claims in the same manner as today*

- **Advanced Practice Nurse**
- **Licensed Clinical Social Worker**
- **School psychology specialists**
- **Other licensed mental health professionals**
- **Mental health paraprofessionals within Behavioral health organizations**
  - Certification requirements forthcoming

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¹ Licensed clinical psychologists eligible to be PAP since guidelines recommend behavioral therapy without medications
Physicians, psychiatrists and licensed clinical psychologists are eligible to serve as the Principal Accountable Provider (PAP)

If only one PAP-eligible provider treats a client, that provider is automatically assigned as the PAP

If multiple PAP-eligible providers treat a client, the provider submitting the most claims will be assigned the PAP

If two PAPs have the same number of claims, the provider with the highest spend will be assigned the PAP

If client is treated by clinicians billing under a Behavioral health provider organization
  – The Behavioral health provider billing organization will be the PAP

1 ODD episode will not include “Co-PAP” since guidelines recommend behavioral therapy without medications
Gain and risk sharing: a Principal Accountable Provider will fall into one of four categories, depending on the provider’s average cost per episode.

Quality metrics must be met in order for PAP to be eligible for gain sharing. Gain sharing/risk sharing percentage is 50%.

Providers over-treating beyond the acceptable threshold subject to downside risk share of costs in excess of this level – shown by the red arrow.

The provider neither gains nor loses because costs are neither above the acceptable threshold nor below the commendable threshold.

**Savings** below the commendable threshold are shared between provider and payer, until the upper limit is reached.

Once the upper limit for savings is reached, the provider receives savings only up to the upper limit level.

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Acceptable threshold: $2,671
Commendable threshold: $1,642
Upper limit: $552
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### Overview of certifications

#### ‘Quality Assessment’ certification
- **For which clients?**
  - All clients new to ODD treatment or entering their first episode model
- **Completion details**
  - Completed after assessment, to initiate treatment
  - Completed by PAP who will deliver care
- **Description**
  - Requires PAPs to certify completion of several guideline-concordant components of assessment
  - Encourages thoughtful and high-quality assessment and diagnosis
  - Encourages appropriate diagnosis of comorbid conditions

#### ‘Continuing Care’ certification
- **For which clients?**
  - All recurring ODD clients within episode model
- **Completion details**
  - Completed at episode recurrence (every 90 days)
  - Completed by PAP who will continue care
- **Description**
  - Requires PAPs to certify adherence to basic quality of care measures and guideline concordant care
  - Requires PAPs to reassess for comorbidities
  - Encourages regular re-evaluation of client and effectiveness of therapy
I hereby certify and attest that I diagnosed the client with ODD and have completed and documented the following in my diagnosis:

- I diagnosed the client through in-person assessment
- I evaluated the client for ODD in accordance with the DSM criteria (listed below)
  - I found ___ (insert number) of the ODD symptoms present for at least six months
- I screened the client for common comorbidities, using comprehensive assessment, broadband diagnostic or similar tool and client family history
- I informed the parent/guardian of the diagnosis, informed him/her of the importance of family involvement, and provided a chance for him/her to express comments about the treatment plan OR I have documented barriers to providing this information
- I have initiated obtaining information that a screen or assessment for learning disability and language impairment was performed in the last two years by communicating with client parents, caregivers, teachers, doctors or reviewing school or medical records OR I completed or arranged for and documented a screen for learning disabilities and language impairments
I hereby certify and attest that I have completed and documented the following in my care of the client with ODD:

- I evaluated client’s ongoing symptoms, impairment, and activities to determine continued necessity of treatment for ODD using reports from at least two settings
- I have re-screened for comorbid behavioral health conditions using comprehensive assessment, broadband diagnostic or similar tool
- I informed the parent/guardian of need for ongoing treatment, informed him/her of the continued importance of family involvement, and provided a chance for him/her to express comments about the treatment plan OR I have documented the barriers to providing this information
- I have obtained information that a screen or assessment for learning disability and language impairment was performed in the last two years by communicating with client parents, caregivers, teachers, doctors or reviewing school or medical records OR I completed or arranged for and documented a screen for learning disabilities and language impairments
- I am providing guideline concordant behavioral therapy management OR I have documented rationale for care outside of guidelines (e.g. in the client chart)
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Paula Miller, HP Research Analyst - Episode Design and Reports
ODD episode design (1/2)

1. Episode definition / scope of services
   - Any ODD treatment (defined by primary diagnosis ICD-9 code), with exception of assessment CPT codes occurring prior to first trigger date, is included in the episode
   - Start of episode: episode begins on first date of treatment
     - For recurring clients, new episode starts on date of first treatment after previous episode ends (e.g., office visit or therapy)
   - The episode will have a duration of 90 days

2. Patient/episode exclusions
   - Episodes meeting one or more of the following criteria will be excluded:
     - Beneficiaries not continuously enrolled in Medicaid during the 90-day episode
     - Beneficiaries with any behavioral health comorbid condition
     - Beneficiaries age 5 or younger and beneficiaries age 18 or older at the time of the initial claim

3. Principal Accountable Provider
   - PCP, psychiatrist or licensed clinical psychologist eligible to be the PAP
   - Behavioral health provider organization will be official PAP when listed as billing provider

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1 3-5 year olds paid fee for service given different evidence-based treatment approach, which is focused on parent/caregiver therapy
Quality metrics required for gain sharing payment:
- Percent of episodes with continuing care or quality assessment certifications (90% minimum)
- Percent of new episodes with medication (20% maximum)
- Percent of repeat episodes with medications (0% maximum)
- Percent of episodes resulting in remission (40% minimum)

Metrics for reporting only:
- Quality: Percent episodes with a minimum of 10 visits
- Quality: Percent episodes that are not guideline concordant
- Quality: Percent episodes with a minimum of 8 family visits
- Utilization: Average number of visits per episode
- Utilization: Average number of behavioral therapy visits per episode
Episode definition / scope of services

An episode begins with client’s first billable treatment for ODD (the first “trigger” claim), defined by claims with primary diagnosis ICD-9 codes matching ODD

Included ICD-9 codes:

- 313.81 – Oppositional Defiant Disorder

- The episode duration is 90 days

- All medical services provided during duration of episode are included to calculate the episode cost for evaluation against cost thresholds
  - Includes all office-visits, psychotherapy, regardless of whether care is guideline-concordant
  - Initial assessment before trigger date excluded from episode payment to encourage complete and thorough diagnosis
  - Medications excluded from episode, but utilization will be monitored as a quality measure to determine gain-share eligibility\(^1\)
  - PAPs may utilize MHPPs as defined by the RSPMI Manual
    - New certifications for MHPPs are being designed, and updates will be reflected in future episode revisions

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\(^1\) Includes therapeutic class ’281608’,’282092’,’281604’,’282004’,’240816’,’281292’,’282492’. Medication is excluded on the basis of clinical advice that occasional clients require medication and because there may be some variation in client needs across providers. However, utilization of medication will be tracked as an outcome measure “to pass.” Percentage of clients not receiving medications “to pass” may be higher with repeat episodes
<table>
<thead>
<tr>
<th><strong>Trigger</strong></th>
<th>ODD episodes are triggered by three medical claims with a primary diagnosis of ODD. The episode begins on the date of the first trigger event.</th>
</tr>
</thead>
</table>
| **PAP assignment** | - Determination of the Principal Accountable Provider (PAP) is based upon which provider is responsible for the largest number of claims within the episode.  
- The provider responsible for the largest number of claims is designated as the PAP. In instances in which two providers are responsible for an equal number of claims within the episode, the provider whose claims accounted for a greater proportion of total reimbursement will be designated PAP.  
- Providers eligible to be PAPs include primary care physicians, psychiatrists, clinical psychologists, and RSPMI provider organizations. |
| **Minimum Case Volume** | The minimum case volume is 5 cases per 12-month period. |
| **Exclusions** | Episodes meeting one or more of the following criteria will be excluded:  
A. Beneficiaries not continuously enrolled in Medicaid during the 90-day episode  
B. Beneficiaries with any behavioral health comorbid condition  
C. Beneficiaries age 5 or younger and beneficiaries age 18 or older at the time of the initial claim |
| **Episode time window** | The standard episode duration is a 90-day period beginning at the time of the first trigger claim. Claims for a beneficiary are tracked for 180 days following the closure of the 90-day standard episode to determine the episode remission rate quality metric. |
| **Claims included** | All claims with a primary diagnosis of ODD. Behavioral health medications will be excluded from the episode, but utilization of medications will be tracked as a quality metric for providers “to pass.” |
| **Quality measures** | Quality measures “to pass”:  
1. Percentage of episodes with completion of either Continuing Care or Quality Assessment certification – must meet minimum threshold of 90% of episodes  
2. Percentage of new episodes (PAPs first ODD episode for this beneficiary) in which the beneficiary received behavioral health medications – must be under maximum threshold of 20%  
3. Percentage of repeat episodes for which the beneficiary received behavioral health medications – must be equal to 0%  
4. Percentage of episodes resulting in beneficiary remission (no repeat ODD episode for this beneficiary with 180 days after the end of the episode) must meet minimum threshold of 40%.  
Quality measures “to track”:  
1. Percentage of episodes with a minimum of 10 visits over 30 days  
2. Percentage of episodes certified as non-guideline concordant  
3. Percentage of episodes with a minimum of 8 family visits  
4. Average number of visits per episode  
5. Average number of behavioral therapy visits per episode |
| **Adjustment** | Only episodes with 10 or more visits over >30 days will be able to reduce a PAP’s average episode cost. PAPs with no episodes with 10 or more visits over >30 days in a performance period will not be eligible for gain sharing. |
Arkansas Health Care Payment Improvement Initiative Provider Report

Medicaid
Report date: October 2013

Historical performance: July 1, 2012 - June 30, 2013

DISCLAIMER: The information contained in these reports is intended solely for use in the administration of the Medicaid program. The data in the reports is neither intended nor suitable for other uses, including the selection of a health care provider. The figures in this report are preliminary and are subject to revision. For more information, please visit www.paymentinitiative.org
Dear Medicaid Provider,

Through the Arkansas Healthcare Payment Improvement Initiative (APII), the State is creating a sustainable multi-payer patient-centered health care system that embraces the Triple Aim of improving (1) population health, (2) patients’ experience of care, and (3) cost effectiveness of care. We are accomplishing this by transforming the vast majority of care and payment from a fragmented, fee-for-service model to a model that rewards and supports providers who consistently deliver high-quality, coordinated, and cost-effective care. A core component of this initiative is episodes of care.

An episode is the collection of care provided to treat a particular condition over a given length of time. For each episode, the provider that holds the main responsibility for ensuring that care is delivered at appropriate cost and quality will be designated as the Principal Accountable Provider (PAP). You have been identified as the PAP for some episodes in the preparatory period in the attached informational report.

The preparatory period refers to the period prior to the first performance reports. During the preparatory period, informational reports will be issued that contain historical claims data about the quality and cost of your care. These informational reports will not impact reimbursement and are designed to assist you in improving cost and quality before the performance period begins. Once the performance period begins, the informational reports will be replaced by performance reports that will directly link your reimbursement levels to quality and cost (e.g., performance reports contain episodes linked to gain or risk sharing).

To aid you in your role as a PAP, your average quality and cost was compared (after appropriate risk-adjustments and exclusions) with previously announced thresholds and the range of performance of other providers to determine any potential sharing of savings or excess cost as indicated in the report. In addition to the report, you should begin using the provider portal at www.paymentinitiative.org to enter selected quality metrics for patients identified within an episode. As you become familiar with your data, reports, and episodes of care, please keep in mind that you should continue to submit and will receive reimbursement for claims as you do today.

We encourage you to visit the APII website at www.paymentinitiative.org to:

- Access the provider portal and download current/prior informational and performance reports.
- View which episodes have quality metrics linked to gain sharing.
- View current and upcoming performance periods.
- Obtain training(webinars), materials, and frequently asked questions.

We have been working diligently to solicit feedback from the provider community and will continue in our efforts to respond to all questions, comments and concerns raised in a timely and consistent manner. You can contact us with questions at 1-866-322-4696, locally at 501-301-8311, or via email ARKPII@hp.com.

Additionally, be sure to check the website regularly for updates or to sign up for alerts.

Sincerely,

Andy Allison, PhD
Medicaid Director

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<th>Period</th>
</tr>
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</tr>
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<td>Attention Deficit/Hyperactivity Disorder (ADHD)</td>
<td>July 1, 2012 - June 30, 2013</td>
</tr>
<tr>
<td>Cholecystectomy</td>
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<td>Colonoscopy</td>
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<td>July 1, 2012 - June 30, 2013</td>
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<td>July 1, 2012 - June 30, 2013</td>
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<td>Upper Respiratory Infection – Non-specific URI</td>
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<td>Upper Respiratory Infection – Pharyngitis</td>
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<tr>
<td>Upper Respiratory Infection – Sinusitis</td>
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<td>Glossary</td>
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<tr>
<td>Appendix: Episode level detail</td>
<td></td>
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</table>
# Performance Summary

## Quality of Services and Cost Summary

<table>
<thead>
<tr>
<th>Episode of Care</th>
<th>Quality of Service</th>
<th>Average Episode Cost</th>
<th>Your Gain/Risk Share</th>
<th>Share Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention Deficit / Hyperactivity Disorder (ADHD) – Level I</td>
<td>Not met</td>
<td>Acceptable</td>
<td>Not eligible for gain sharing</td>
<td>$0.00</td>
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<tr>
<td>Attention Deficit / Hyperactivity Disorder (ADHD) – Level II</td>
<td>Met</td>
<td>Acceptable</td>
<td>Not eligible for gain sharing</td>
<td>$0.00</td>
</tr>
<tr>
<td>Cholecystectomy</td>
<td>Met</td>
<td>Acceptable</td>
<td>Not eligible for gain sharing</td>
<td>$0.00</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>Met</td>
<td>Acceptable</td>
<td>Not eligible for gain sharing</td>
<td>$0.00</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>Not met</td>
<td>Acceptable</td>
<td>Not eligible for gain sharing</td>
<td>$0.00</td>
</tr>
<tr>
<td>Oppositional Defiance Disorder</td>
<td>Met</td>
<td>Acceptable</td>
<td>Not eligible for gain sharing</td>
<td>$0.00</td>
</tr>
<tr>
<td>Perinatal</td>
<td>Met</td>
<td>Acceptable</td>
<td>Not eligible for gain sharing</td>
<td>$0.00</td>
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<tr>
<td>Tonsillectomy</td>
<td>Met</td>
<td>Acceptable</td>
<td>Not eligible for gain sharing</td>
<td>$0.00</td>
</tr>
<tr>
<td>Total Joint Replacement</td>
<td>N/A</td>
<td>Acceptable</td>
<td>Not eligible for gain sharing</td>
<td>$0.00</td>
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<tr>
<td>Upper Respiratory Infection – Non-specific URI</td>
<td>N/A</td>
<td>Not acceptable</td>
<td>Subject to risk sharing</td>
<td>-$3,000.00</td>
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<tr>
<td>Upper Respiratory Infection – Pharyngitis</td>
<td>Not met</td>
<td>Acceptable</td>
<td>Not eligible for gain sharing</td>
<td>$0.00</td>
</tr>
<tr>
<td>Upper Respiratory Infection – Sinusitis</td>
<td>N/A</td>
<td>Commendable</td>
<td>Will receive gain sharing</td>
<td>$349.50</td>
</tr>
</tbody>
</table>

Across these Episodes of Care You are Subject to Risk Sharing: Stop-loss was applied **-$3,000.00**

The figures in this report are preliminary and are subject to revision.
Summary – Oppositional Defiant Disorder (ODD)

1 | Overview
Total episodes: 262
Total episodes included: 233
Total episodes excluded: 29

2 | Cost of care compared to other providers
Commendable: < $1,642
Acceptable: $1,642 to $2,671
Not acceptable: > $2,671

Gain/Risk share
You: $0
All providers
You will not receive gain or risk sharing
Selected quality metrics: N/A
Average episode cost: Acceptable

3 | Quality summary
You achieved selected quality metrics
Linked to gain sharing
Selected quality data submitted on the Provider Portal will generate additional quality metrics for future reports.

% Episodes > 9 visits

% Episodes w/ remission

% New episodes w/ meds

% Episodes > 7 family visits

4 | Cost summary
Your average cost is acceptable
Total cost overview, $:
You: 512,000
All providers: 466,000
Average cost overview, $:
You: 2,000
All providers: 1,750

Your episode cost distribution
Distribution of provider average episode cost

5 | Key utilization metrics
Average number of visits per episode
You: 11
All providers: 14
Average number of behavioral visits per episode
You: 11
All providers: 7
# Quality and Utilization Detail – ODD

## 1. Quality Metrics: Performance Compared to Provider Distribution

<table>
<thead>
<tr>
<th>Metric</th>
<th>You</th>
<th>Percentile</th>
<th>Metric</th>
<th>Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>% with completed certification (TBD)</td>
<td></td>
<td></td>
<td>You</td>
<td></td>
</tr>
<tr>
<td>% episodes w/ remission (based on episodes w/ 180 day run-out)</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>5%</td>
</tr>
<tr>
<td>% new episodes with medication</td>
<td>15%</td>
<td>10%</td>
<td>20%</td>
<td>30%</td>
</tr>
<tr>
<td>% repeat episodes w/ medication</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>5%</td>
</tr>
<tr>
<td>% episodes with &gt; 9 visits</td>
<td>48%</td>
<td>25%</td>
<td>52%</td>
<td>75%</td>
</tr>
<tr>
<td>% non-guideline concordant (TBD)</td>
<td></td>
<td></td>
<td>You</td>
<td></td>
</tr>
<tr>
<td>% episodes with &gt; 7 family visits</td>
<td>48%</td>
<td>25%</td>
<td>52%</td>
<td>75%</td>
</tr>
</tbody>
</table>

![Achieved Quality Metrics]

## 2. Utilization Metrics: Performance Compared to Provider Distribution

<table>
<thead>
<tr>
<th>Metric</th>
<th>You</th>
<th>Percentile</th>
<th>Metric</th>
<th>Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average number of visits per episode</td>
<td>4.1</td>
<td>2.3</td>
<td>3.9</td>
<td>4.3</td>
</tr>
<tr>
<td>Average number of behavioral visits per episode</td>
<td>62</td>
<td>15</td>
<td>38</td>
<td>74</td>
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</tbody>
</table>
# Cost detail – Oppositional Defiant Disorder (ODD)

**Total episode included = 233**

<table>
<thead>
<tr>
<th>Care category</th>
<th># and % of episodes with claims in care category</th>
<th>Average cost per episode when care category utilized $</th>
<th>Total vs. expected cost in care category, $</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient professional</strong></td>
<td>233 100%</td>
<td>550</td>
<td>128,150</td>
</tr>
<tr>
<td></td>
<td></td>
<td>500</td>
<td>116,500</td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td>230 99%</td>
<td>2,415</td>
<td>555,450</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2,400</td>
<td>552,000</td>
</tr>
<tr>
<td><strong>Emergency department</strong></td>
<td>221 95%</td>
<td>76</td>
<td>16,796</td>
</tr>
<tr>
<td></td>
<td></td>
<td>76</td>
<td>16,796</td>
</tr>
<tr>
<td><strong>Outpatient lab</strong></td>
<td>184 79%</td>
<td>81</td>
<td>14,904</td>
</tr>
<tr>
<td></td>
<td></td>
<td>81</td>
<td>14,904</td>
</tr>
<tr>
<td><strong>Outpatient radiology / procedures</strong></td>
<td>21 75%</td>
<td>117</td>
<td>2,457</td>
</tr>
<tr>
<td></td>
<td></td>
<td>95</td>
<td>1,995</td>
</tr>
<tr>
<td><strong>Inpatient professional</strong></td>
<td>16 78%</td>
<td>70</td>
<td>1,120</td>
</tr>
<tr>
<td></td>
<td></td>
<td>75</td>
<td>1,200</td>
</tr>
<tr>
<td><strong>Inpatient facility</strong></td>
<td>12 5%</td>
<td>69</td>
<td>828</td>
</tr>
<tr>
<td></td>
<td></td>
<td>62</td>
<td>744</td>
</tr>
<tr>
<td><strong>Outpatient surgery</strong></td>
<td>1 &lt;1%</td>
<td>97</td>
<td>97</td>
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<tr>
<td></td>
<td></td>
<td>84</td>
<td>84</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>7 3%</td>
<td>25</td>
<td>175</td>
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<tr>
<td></td>
<td></td>
<td>27</td>
<td>189</td>
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</tbody>
</table>

# and % of episodes with claims in care category

**Care category**
- Outpatient professional
- Pharmacy
- Emergency department
- Outpatient lab
- Outpatient radiology / procedures
- Inpatient professional
- Inpatient facility
- Outpatient surgery
- Other

**Average cost per episode when care category utilized**

- Outpatient professional: 550, 500
- Pharmacy: 2,415, 2,400
- Emergency department: 76, 76
- Outpatient lab: 81, 81
- Outpatient radiology / procedures: 117, 95
- Inpatient professional: 70, 75
- Inpatient facility: 69, 62
- Outpatient surgery: 97, 84
- Other: 25, 27

**Total vs. expected cost in care category**

- Outpatient professional: 128,150, 116,500
- Pharmacy: 555,450, 552,000
- Emergency department: 16,796, 16,796
- Outpatient lab: 14,904, 14,904
- Outpatient radiology / procedures: 2,457, 1,995
- Inpatient professional: 1,120, 1,200
- Inpatient facility: 828, 744
- Outpatient surgery: 97, 84
- Other: 175, 189
**Detailed Oppositional Defiant Disorder (ODD) cost information for Dr. Joe Smith**

<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>
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<tr>
<td>67061</td>
<td>Mark Smith</td>
<td>N/A</td>
<td>01/13/13 02/01/13</td>
<td>$</td>
<td>$</td>
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<tr>
<td>67220</td>
<td>Ali Cross</td>
<td>Y</td>
<td>01/15/13 02/04/13</td>
<td>$</td>
<td>$</td>
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<tr>
<td>660212</td>
<td>Frank Cole</td>
<td>Y</td>
<td>02/19/13 03/09/13</td>
<td>$</td>
<td>$</td>
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<tr>
<td>821520</td>
<td>Mark Smith</td>
<td>Y</td>
<td>04/13/13 05/02/13</td>
<td>$</td>
<td>$</td>
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<tr>
<td>844563</td>
<td>Jade Paul</td>
<td>Y</td>
<td>04/21/13 05/11/13</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>124445</td>
<td>Craig Hansen</td>
<td>N</td>
<td>51/14/13 06/03/13</td>
<td>$</td>
<td>$</td>
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<tr>
<td>60236</td>
<td>Bill Wilson</td>
<td>Y</td>
<td>05/14/13 06/03/13</td>
<td>$</td>
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<tr>
<td>623011</td>
<td>Molly Smith</td>
<td>N</td>
<td>06/02/13 06/22/13</td>
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<tr>
<td>324577</td>
<td>Jerry Frank</td>
<td>Y</td>
<td>06/03/13 06/23/13</td>
<td>$</td>
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<tr>
<td>115320</td>
<td>Tim Weston</td>
<td>Y</td>
<td>06/27/13 06/27/13</td>
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<tr>
<td>112447</td>
<td>Rahul Palwar</td>
<td>Y</td>
<td>06/27/13 06/27/13</td>
<td>$</td>
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<tr>
<td>600221</td>
<td>Elijah James</td>
<td>Y</td>
<td>06/07/13 06/27/13</td>
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<td>727939</td>
<td>Bill Wilson</td>
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<td>06/09/13 06/29/13</td>
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<td>900291</td>
<td>Will Bradley</td>
<td>N</td>
<td>06/10/13 06/30/13</td>
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<td>600527</td>
<td>Matt Jackson</td>
<td>Y</td>
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ODD timeline overview

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<tr>
<th>Activity</th>
<th>2013</th>
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<th>2016</th>
<th>2017</th>
<th>2018</th>
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<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Q1</td>
<td>Q2</td>
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<tr>
<td>Performance period 1</td>
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<tr>
<td>4/1/14-3/31/15</td>
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<tr>
<td>Performance period 2</td>
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<tr>
<td>4/1/15-3/31/16</td>
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<td>Performance period 3</td>
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01-Apr-2014
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