DRAFT

Arkansas Payment Improvement Initiative

Discussion document
Behavioral Health / ADHD

March 7th, 2012

PRELIMINARY WORKING DRAFT, SUBJECT TO CHANGE

Objectives for today and what's coming up

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- Review and get your feedback on version 1.0 design elements specific to the ADHD episode
- Review historical data for ADHD episodes based on version 1.0 design
- Briefly review episode design elements common across episodes

What's coming up

- Third round of workgroups for each of the clinical areas underway through March 14
- Late March: in-depth discussion of design elements common across clinical areas (participants from all workgroups invited to attend)
- May/June: release and review of version 1.0 episode design refined based on stakeholder input

July 1st launch: what to expect

Key milestones	Description	Timing
▪ **Description of design elements across episodes**	▪ In-depth discussion of design elements common across clinical areas (participants from all workgroups invited to attend)	March 26th March 28th
▪ **Program announcement and education**	▪ Payment design and documentation published ▪ Educational workgroups and town halls to answer questions	May/ June
▪ **Program launch**	▪ All analytic/ reporting engines up and running	July 1st
▪ **Reporting period (3-6 months)**	▪ Principal Accountable Providers (PAP) receive baseline historical performance reports ▪ Analytic/ reporting engines track "virtual" performance for each PAP ▪ Performance does not yet impact payment	July 1st
▪ **Feedback period**	▪ Workgroups provide feedback on version 1.0 ▪ Payors may refine version 1.0 design	July 1st – Sep 1st
▪ **Performance period begins**	▪ New episodes begin to count towards a PAP's share of risk or gain sharing	Q4 2012 or Q1 2013

Recap: goals of Payment Initiative compared with fee-for-service

- ✓ Reward high-quality care and outcomes
- ✓ Encourage clinical effectiveness
- ✓ Promote early intervention and coordination to reduce complications and associated costs
- ✓ Encourage referral to higher-value downstream providers

Recap: Episode-based care delivery will be paid for using an "episode performance payment" model[1]

How episode performance payment will work:

- A cost threshold is determined for an episode
- One or more providers is designated the Principal Accountable Provider (PAP)
- Providers initially paid separately for the care they deliver, filing claims as they do today
- At the end of the episode, average costs and quality for the entire episode are aggregated and compared with the pre-determined threshold
- Savings or excess costs are divided between the PAP(s) and the payor or plan sponsor[2]
- While only PAPs directly receive a share of gain or risk from the payor, these providers may in turn choose to share incentives or risk with one or more other participating providers, subject to any legal limitations
- While the episode model inherently incents high quality care, PAPs will not be eligible for gain sharing unless certain quality thresholds are met

1 We have previously described this as a “retrospective reconciliation” method of episode-based payment
2 Upside and downside risk or gain sharing will be made at period intervals (i.e., at the end of a performance period)

Agenda for today

- **Discuss ADHD episode clinical foundation and version 1.0 structure**
- Review detailed version 1.0 episode design decisions
- Review historical data for the ADHD episode based on version 1.0 design
- Briefly review episode design elements common across episodes (for further discussion in late March)

Clinical foundation: 'Version 1.0' will include patients aged 6 – 17 without behavioral health comorbid conditions[1]

	Treatment recommended in AAP/AACAP guidelines[2]	Not indicated by evidence-based guidelines
I **ADHD with no BH co morbid conditions, positive response to medication**	▪ 4 - 6 physician visits / year ▪ Rx ▪ Parent / Teacher administered behavioral support[3]	▪ Psychosocial therapy – In-office psychotherapy – Group psychotherapy
II **ADHD with no co morbid conditions, sub-optimal response to medication**	▪ 6 physician visits / year ▪ Rx ▪ Parent / Teacher administered behavioral support[3] ▪ Psychosocial therapy if needed	
		Included in version 1.0
III **ADHD and Behavioral Health comorbid condition(s)**	▪ Varies by comorbidity ▪ Significant psychiatric involvement necessary	**Note: all services currently billable for each payor will continue to be billable. Recommended treatment will only be utilized in setting benchmark prices.**

1 4 – 5 year olds will continue to be paid fee-for-service in version 1.0 because of limited evidence-based treatment guidelines and consensus
2 Based upon American Academy of Pediatrics Clinical Practice Guidelines (2011); American Academy of Child and Adolescent Psychiatry Practice Parameters (2007)
3 Defined as education via books, videos, or a one-time series of in-person training sessions

SOURCE: American Academy of Child and Adolescent Psychiatry, 2007; American Academy of Pediatrics, 2011; Scottish Intercollegiate Guidelines Network, 2009; Canadian ADHD Resource Alliance Guidelines, 2011; 7 interviews with clinical experts, including pediatricians, child psychiatrists, and child psychologists

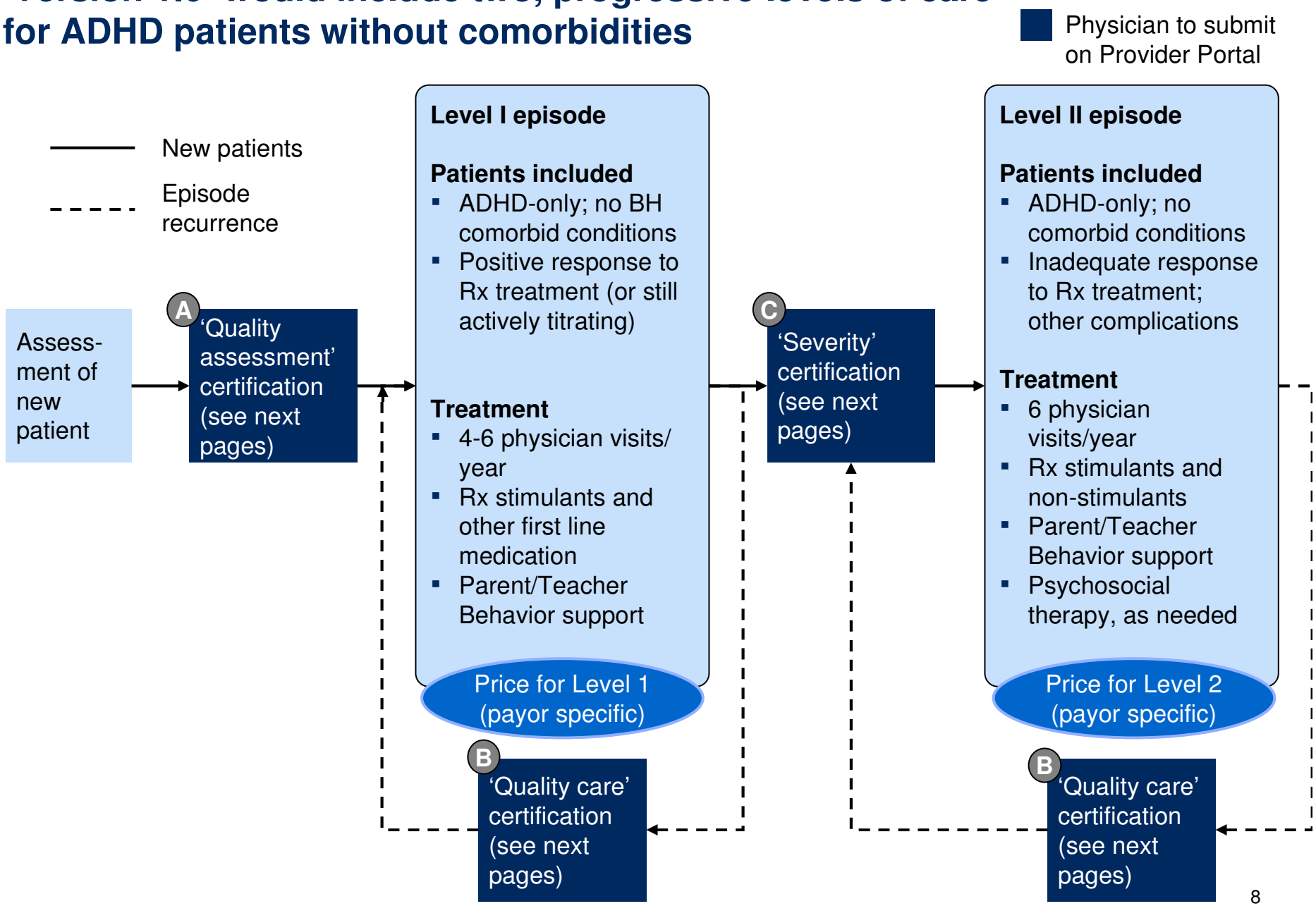
Proposed approach

- **Two patient severity levels for ADHD patients aged 6 – 17 without behavioral health comorbid conditions[1]**
  - Patients with positive response to medication management
  - Patients for whom response to medication management is inadequate and therefore psychosocial interventions are medically indicated
- **A separate set of cost thresholds would be established for both levels of severity, based upon treatment guidelines, literature, historical costs in Arkansas, and will differ by payor**
- **All patients new to treatment would begin in level one care**
  - e.g. psychostimulant medication and parent / teacher administered behavior support
- **For patients with inadequate response to level one care, provider certification of suboptimal response to guideline concordant care would be required to increase to level two care**
  - e.g. psychostimulant medication, nonstimulant medication, and limited psychosocial therapy
- **Provider submits certification through user-friendly, online Provider Portal, a new tool for providers to submit certifications and clinical information**

1 4 – 5 year olds will continue to be paid fee-for-service in version 1.0 because of limited evidence-based treatment guidelines and consensus

Preliminary working draft; subject to change

'Version 1.0' would include two, progressive levels of care for ADHD patients without comorbidities



Certification would be required at the key points in care: entry into system, episode recurrence, and increase in severity

	For which patients?	Completion details	Description
A 'Quality Assessment' certification	▪ All patients new to treatment entering episode model	▪ Completed after assessment, to initiate treatment ▪ Completed by provider who will deliver care	▪ Requires providers to certify completion of several guideline-concordant components of assessment ▪ Encourages thoughtful and high-quality assessment and diagnosis ▪ Encourages appropriate diagnosis of comorbid conditions
B 'Quality care' certification'	▪ All recurring ADHD patients within episode model	▪ Completed at episode recurrence (every 12 months) ▪ Completed by provider who will continue care	▪ Requires providers to certify adherence to basic quality of care measures and guideline concordant care ▪ Encourages regular re-evaluation of patient and management at physician level
C 'Severity' certification	▪ All patients escalated to level 2 care, whether first-time or recurring	▪ Completed at initial escalation and every level two episode recurrence ▪ Completed by provider who will deliver level two care	▪ Requires providers to certify severity for patients placed into level two care ▪ Completed by physician providing level two care

Illustrative 'Quality Assessment' and 'Quality Care' certification

A

'Quality Assessment' certification

Completed for each new patient

I hereby certify and attest that I diagnosed the patient with ADHD, have completed and documented the following in my diagnosis:

- I completed and documented a vision & hearing test OR I confirmed that test was completed within the year by a PCP
- I evaluated the patient for ADHD in accordance with the DSM-IV criteria
- I diagnosed the patient through in-person assessment and reports from least two settings
- I screened the patient for common comorbidities, using a broadband diagnostic or similar tool
- I obtained the patient's family history, including any incidence of the disorder in parents or guardians which might influence treatment pathway OR I attempted to collect a family history but was unable to obtain
- (If not the PCP) I alerted the PCP to my diagnosis and any initial treatment I have prescribed

B

'Quality Care' certification

Completed for each episode renewal (e.g. every 12 months)

I hereby certify and attest that I have completed and documented the following in my care of the patient with ADHD:

- I evaluated patient's ongoing symptoms, impairment, and activities to determine continued necessity of treatment for ADHD, screening for comorbidities if appropriate
- I am providing guideline concordant medication management OR
- I have documented complete rationale for care outside of guidelines
- (If not the PCP) I alerted the PCP to any changes in treatment regimen and side effects of medication

Illustrative 'Severity Certification', which would be completed for every ADHD patient escalated to Level 2 episode

C

'ADHD severity' certification

Completed for each patient escalated to Level 2 episode

I hereby certify that I diagnose the patient with ADHD, have screened for and not found comorbid conditions, that the patient has an inadequate response to guideline concordant medication management, and that further treatment is clinically necessary for one or more of the following rationale (select one or multiple reasons):

- Inadequate response to medication management
- Severe side effects of medication
- Major environmental or familial complications (e.g. homeless parents, high likelihood of medication diversion, etc)
- Other (please enter explanation)

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- **Review detailed version 1.0 episode design decisions**
- Review historical data for the ADHD episode based on version 1.0 design
- Briefly review episode design elements common across episodes (for further discussion in late March)

Preliminary proposal: version 1.0 design elements specific to ADHD

1 Episode definition/ scope of services

- Any ADHD treatment (defined by primary diagnosis ICD-9 code), with exception of assessment CPT codes, is included in the episode
- Start of episode
  - For new patients, episode begins on date of treatment initiation
  - For recurring patients, new episode starts on date of first treatment after previous episode ends (e.g. Rx filled or office visit)
- The episode will have a duration of 12 months

2 Principal accountable provider(s)

- PCP, Psychiatrist or licensed clinical psychologist eligible to be the PAP
  - For Version 1.0, RSPMI provider organization will be official PAP when listed as billing provider, but reporting will be provided at clinician level, where available
- If licensed clinical psychologist treats patient, a co-PAP is required and providers share gain / risk sharing

3 Patient severity levels and exclusions

- Includes all ADHD patients aged 6 – 17 without behavioral health comorbid conditions[1]
- Two patient severity levels will be included
  - Patients with positive response to medication management, requiring only medication and parent / teacher administered support
  - Patients for whom response to medication management is inadequate and therefore psychosocial interventions are medically indicated
- Severity will be determined by a provider certification

1 4 – 5 year olds will continue to be paid fee-for-service in version 1.0 because of limited evidence-based treatment guidelines and consensus

1 Episode definition/ scope of services: overview and criteria

An episode begins with patient's first billable treatment for ADHD, defined by claims with primary diagnosis ICD-9 codes matching ADHD

Included ICD-9 codes:

- 314 – Hyperkinetic syndrome of childhood
- 314.0 – Attention deficit disorder
- 314.00 – Attention deficit disorder, predominantly inattentive type
- 314.01 – Attention deficit disorder combined type
- 314.1 – Hyperkinesis with developmental delay
- 314.2 – Hyperkinetic conduct disorder
- 314.8 – Other hyperkinetic syndrome
- 314.9 – Unspecified hyperkinetic syndrome

- The episode duration is 12 months
- All medical services provided during duration of episode are included to calculate the episode cost for evaluation against benchmark cost
  - Includes all office-visits, medication management, psychotherapy regardless of whether care is guideline-concordant
  - Assessment excluded from episode payment to encourage complete and thorough diagnosis
- All medication commonly prescribed for ADHD is included

1 Episode definition/ scope of services: initial list medications for which cost is counted against overall episode cost

DRAFT – FOR DISCUSSION

Listed drugs are included if the prescription is filled within the course of the episode

Medication included in episode design	
Adderall	Intuniv
Adderall IR	Intuniv ER
Adderall XR	Metadate
Amphetamine	Metadate CD
Catapres	Metadate ER
Catapres-TTS	Methylfin
Clonidine	Methylin
Concerta	Methylin ER
Concerta ER	Methylphenidate
Daytrana	Ritalin
Dexedrine	Ritalin LA
Dexmethylphenidate	Ritalin SR
Dextroamphetamine ER	Strattera
Focalin	Vyvanse
Focalin XR	All other psychoactive drugs (e.g. atypical antipyschotics, SSRIs)

Only patients 6 – 17 without comorbid conditions are included in version 1.0

2 Principal accountable providers: overview and criteria

Two types of providers for an episode of care:

- **Principal accountable provider (PAP)**:
  - Provider with which payor directly shares upside/risk for cost relative to benchmark
  - Receives performance reports, organizes team to drive performance improvement
  - May be physician practice, hospital, or other provider
- **Other participating provider(s)**:
  - Any provider that delivers services during an episode that is not a PAP
  - Payors do not directly share in upside/risk for cost relative to benchmark

Payors will identify one (or two if necessary) principal accountable provider(s) for each episode of care

- *Focuses accountability*
- *Ensures sufficient upside/downside to motivate behavior change*
- *Simplifies administration*

Qualifications for a Principal Accountable Provider

☑ **Decision-making responsibility:** provider is principal (not exclusive) decision maker for most care during episode
  - Selects tests/ screenings
  - Determines treatment approach
  - Carries out procedures

☑ **Influence over other providers**: provider is in best position to coordinate with, direct, or incent participating providers to improve performance
  - Makes referral decisions
  - Provides infrastructure
  - Organizes quality improvement efforts

☑ **Economic relevance**: provider bears a material portion of the episode cost or a significant case volume

2 Principal accountable providers: eligible providers

Eligible to serve as PAP

Providers will bill their claims in the same manner as today

- **Primary care physicians**
  - Pediatricians, Family Practice physicians
- **Psychiatrists**
  - Private practice or within RSPMI provider organizations
- **Licensed clinical psychologists in private practice (require co-PAP)**
  - Ph.D. or Psy.D training; licensed according to state requirements
  - Private practice psychologist would require a co-PAP to write scripts
- **RSPMI provider organization (Licensed clinical psychologists or psychiatrist)**
  - The RSPMI billing organization will be the Principal Accountable Provider
  - Reporting will be at clinician level where available

Eligible to provide care, but not to serve as PAP in version 1.0

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-based psych examiner**
- **Other licensed mental health professionals**
- **Mental health paraprofessionals within RSPMI organizations**
  - No certification required in version 1.0, but certification expected for later versions

2 Principal accountable providers: version 1.0 PAP attribution logic

- **Only physicians and licensed clinical psychologists are eligible to serve as the Principal Accountable Provider**
  - Clinical psychologist in private practice would require a co-PAP with the ability to write scripts
- **If only one PAP-eligible provider treats a patient, that provider is automatically assigned as the Principal Accountable Provider**
- **If patient is treated by clinicians billing under an RSPMI organization**
  - The RSPMI billing organization will be the Principal Accountable Provider
  - Where possible, reporting will identify individual clinician(s) within PAP who provide treatment
- **If patient is treated by a licensed clinical psychologist, another PAP-eligible provider must serve as the co-PAP**
  - Gain and risk sharing among all co-Principal Accountable Providers

2 Principal accountable providers: sample pathways and assigned principal accountable provider

Provides majority of care | Consultation only

Patient may see a non-PAP eligible provider before entry into episode pathway
- e.g. school psych examiner may see patient, then refer to PCP

	Point of entry and initial assessment	Referral or consultation (if any)	PAP
1	PCP		PCP
2	PCP	Independent mental health professional (not Ph.D.)	PCP
3	PCP	Licensed clinical psychologist	Co-PAPs
4	PCP	Licensed clinical psychologist	PCP
5	PCP	Psychiatrist	PCP
6	PCP	Psychiatrist	Psychiatrist
7	PCP	Psychiatrist or psychologist within RSPMI	PCP
8	PCP	Psychiatrist or psychologist within RSPMI	RSPMI billing organization
9	Psychiatrist		Psychiatrist
10	Licensed clinical psychologist	PCP	Co-PAPs
11	Licensed clinical psychologist	PCP	PCP
12	Licensed clinical psychologist	Psychiatrist	Co-PAPs
13	Licensed clinical psychologist	Psychiatrist	Psychiatrist
14	Psychiatrist or psychologist within RSPMI	PCP	PCP
15	Psychiatrist or psychologist within RSPMI	(PCP referral required within 90 days)	RSPMI billing organization

Emerging answers to provider frequently asked questions

How often will providers be provided information on their patients?

- We expect to provide a report every quarter, which will include[1]
  - A list of all patients for whom that provider is the Principal Accountable Provider in an ongoing episode, including current cumulative costs for episode
  - List of episodes which completed in the reporting period, including detailed costs and comparison of average cost / episode to cost thresholds
- Reconciliation payments will initially occur every six to twelve months

How will current patients be included?

- Following the same logic as new patients, episodes will be initiated for current patients on the first date of treatment
- Current patients will begin at level 1 care and the time restriction on severity certification will be waived (e.g. providers will be allowed to certify severity immediately)
- Providers should complete certifications on first patient visit after episode launch

What is the time window required between level one and level two severity?

- For all new patients within the system, providers will be allowed to certify severity after two months of treatment
- For current patients, time window will be waived during episode model roll-out

1 Subject to technical feasibility for version 1.0

Agenda for today

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- Review detailed version 1.0 episode design decisions
- **Review historical data for the ADHD episode based on version 1.0 design**
- Briefly review episode design elements common across episodes (for further discussion in late March)

Historical data is undergoing final analysis and will be provided to participants at the ADHD workgroup on Wednesday, March 7th at UAMS and all video-conference locations.

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- Review detailed version 1.0 episode design decisions
- Review historical data for the ADHD episode based on version 1.0 design
- **Briefly review episode design elements common across episodes (for further discussion in late March)**

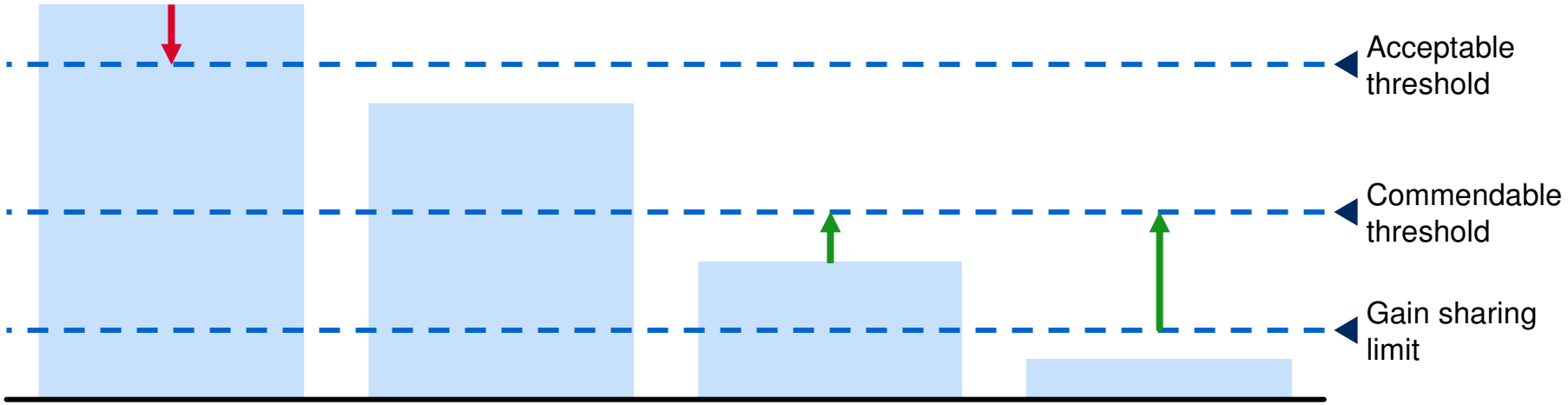
In addition, version 1.0 episode design will incorporate several design elements common across clinical areas

	Description
a Payment mechanics	▪ Structure of risk and gain sharing arrangements ▪ Transition vs. end-state model
b Other patient-level adjustments	▪ Patient risk/severity adjustments ▪ Outlier exclusions on a cost basis
c Provider-level adjustments	▪ Stop-loss provisions ▪ Adjustments for providers in areas with poor physician access ▪ Adjustments for critical access hospitals ▪ Adjustments for differences in regional pricing ▪ Adjustments or exclusions for providers with low case-volume

More in-depth discussion of these dimensions scheduled for late March (participants from all clinical workgroups invited to attend)

Gain and risk sharing: a Principal Accountable Provider will fall into one of four categories, depending on the provider's average cost per episode

Average cost per episode, for each Principal Accountable Provider



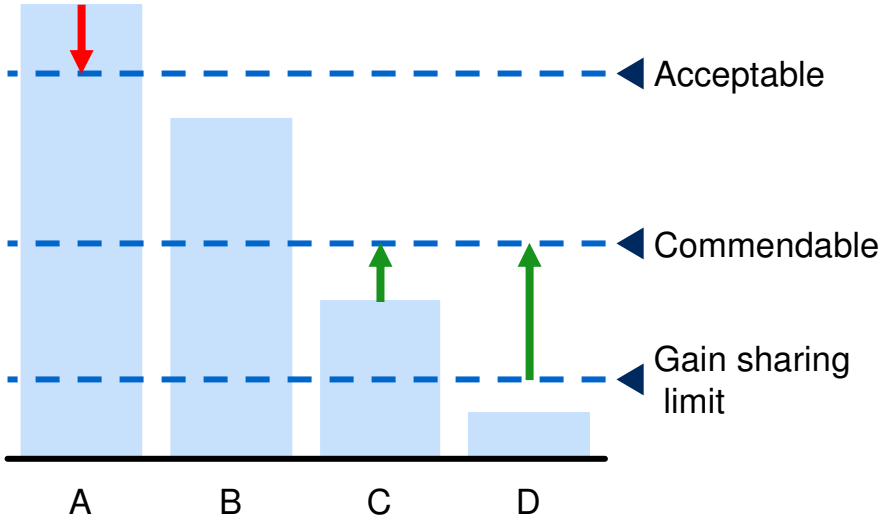
Sub-par performance	Acceptable performance	Commendable performance	Beyond commend-able performance
Providers whose costs exceed the acceptable threshold will be held **responsible for a share of costs above this threshold** – shown by the red arrow	The provider **neither gains nor loses** because costs are neither above the acceptable threshold nor below the commendable threshold	**Savings** below the commendable threshold – shown by the green arrow – **are shared** between provider and payor, until the gain sharing limit is reached	The provider will receive a share of **savings up to a gain sharing limit, but not beyond**

Note: in the coming months, each participating payor will determine the level of upside and downside sharing for each episode

Gain and risk sharing: a transition period will expose fewer providers to downside risk

Transition period

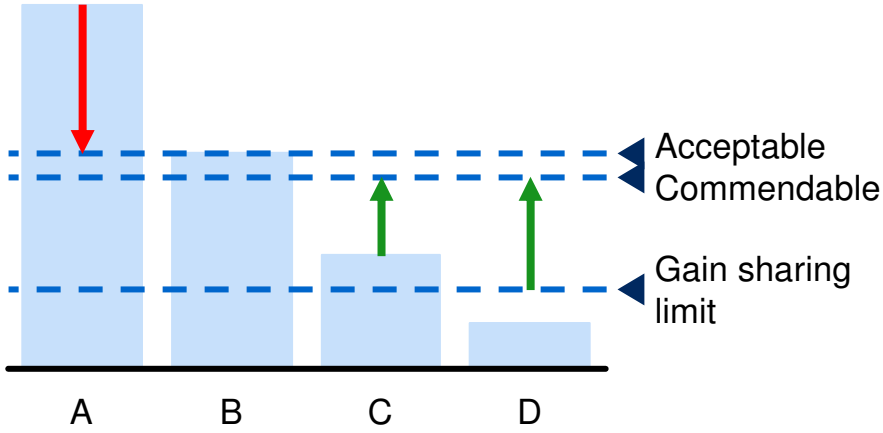
Average cost per episode, for each Principal Accountable Provider



- Higher acceptable threshold (fewer providers exposed to downside risk)
- Providers begin implementing practice changes to meet outlined post-transition thresholds

Post-transition period

Average cost per episode, for each Principal Accountable Provider



- Acceptable threshold will be brought closer to the commendable threshold
- Commendable threshold will be brought to post-transition level

Guiding principle: give providers the time and resources to change practice patterns and improve performance before full risk and gain sharing is in effect