PRELIMINARY DRAFT

Health Care Payment Improvement Initiative

Building a healthier future for all Arkansans

Initial Findings on Payment Improvement Episodes

JULY 2013

Early indicators of impact: URI

- The principal source of value for the URI episode is to encourage appropriate use of antibiotics and other treatments to ensure patient needs are being met while improving quality and public health outcomes
- In the first 3 months of the episode performance period (October – December 2012), the frequency of drug prescriptions for URI episodes decreased by 3.3 percentage points compared with the same period in the prior year, and five percentage points for unspecified URI, in particular (the most common type of URI)
- This favorable change in physician behavior has helped to control the rate of increase in cost per episode, offsetting increases in drug prices over the past year

Note: Based on preliminary analysis of episode performance and claims data available as of June 28, 2013

Episode data indicates the overall drug utilization rate dropped across URI sub-episodes

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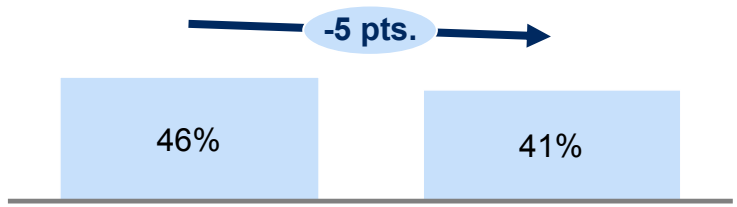
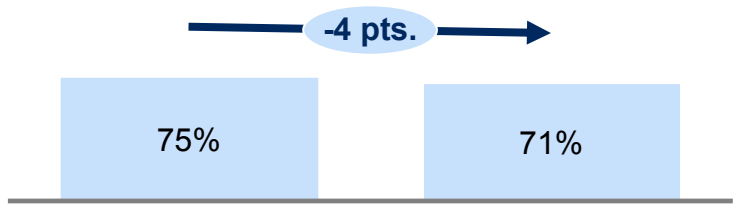
Change in utilization of medication
% of episodes with pharmacy claims[1]

Unspecified URI



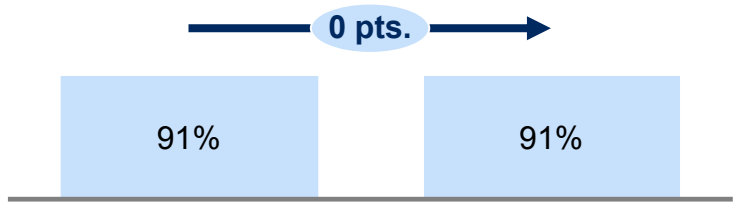
Total # of episodes	Oct 11- Dec 11	Oct 12- Dec 12
	16,782	15,834

Pharyngitis



Total # of episodes	Oct 11- Dec 11	Oct 12- Dec 12
	15,748	14,883

Sinusitis



Total # of episodes	Oct 11- Dec 11	Oct 12- Dec 12
	6,192	6,473

1 Only includes PAPs with >4 Episodes
Source: Episodes Performance reports covering Jan 11- Dec 12

Early indicators of impact: Perinatal

- The principal sources of value for the perinatal episode are to support more effective prenatal care, decrease the utilization of elective procedures, and ensure appropriate length of stay
- Since there are not yet any completed episodes starting after October 1st 2012 and with live births after January 1st 2013, it is too early to fully determine the impact of the episode on prenatal care
- However, the c-section rate for deliveries in January-February 2013 was approximately 5 percentage points lower versus the same period in 2012 (35% vs. 40%), reversing an upward trend observed in the prior year
- Further analysis is still pending for early inductions, length of stay, and average cost per episode

Note: Based on preliminary analysis of claims data available as of June 28, 2013

% of live births via C-section

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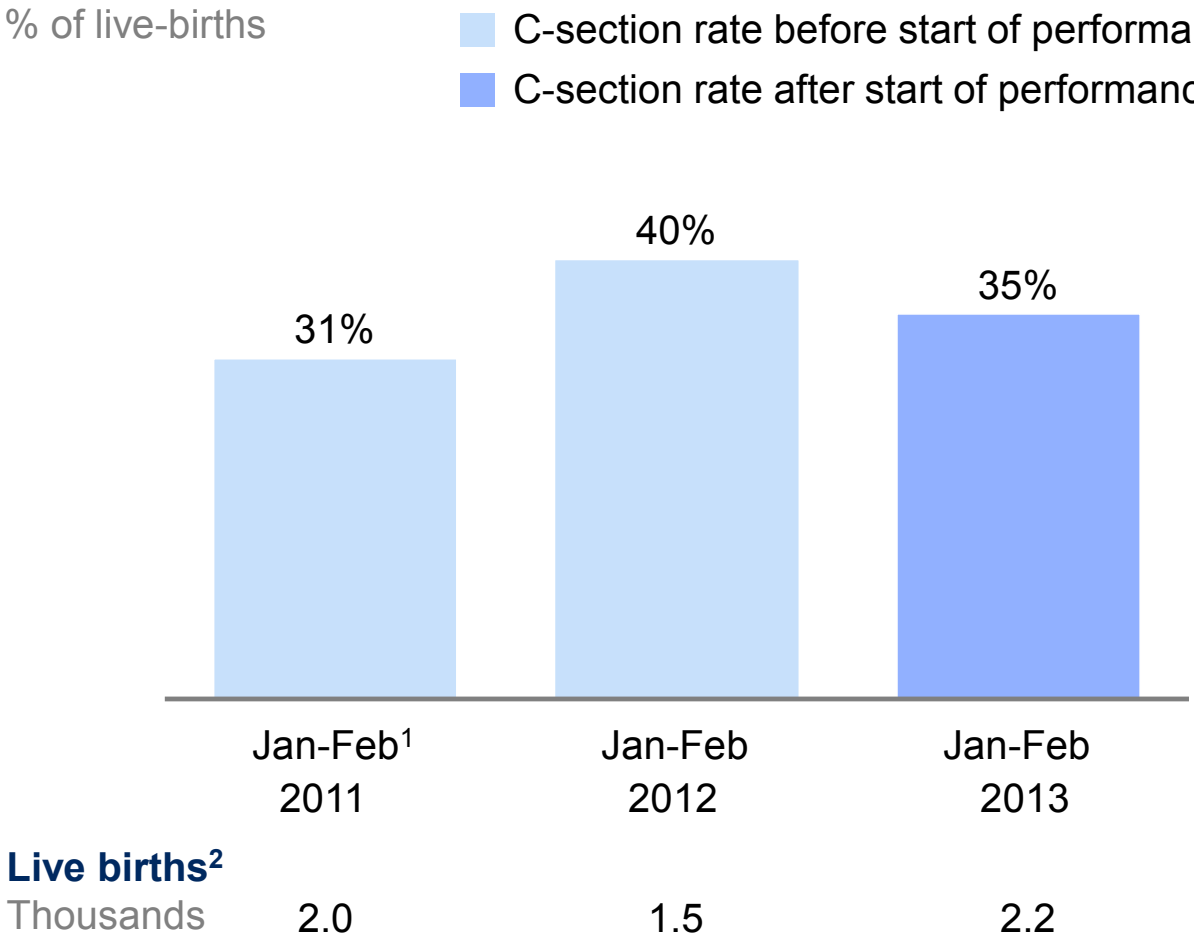
C-section rate



- After program start, the c-section rate dropped 5 percentage points
- However, the c-section rate has risen 4 percentage points in total over the past 3 years
- As more data becomes available it will be necessary to further explore underlying trends and root causes of this change

1 Jan and Feb are compared because only live births after Jan are included in the episode and currently available data extends to the end of February
2 All data based on claims - not production level episodes. Changes are expected as more data becomes available

Source: Medicaid claims data Jan 2011 – March 2013, data pull from Arkansas Center for Health Improvement (ACHI) as of 4/22/2013

Early indicators of impact: ADHD

- The principal sources of value for the ADHD episode are to support the accurate diagnosis and efficient delivery of guideline-concordant care

- Since the start of the episode performance period, the number of claims coded each month with an ADHD primary diagnosis (both ADHD only and ADHD with behavioral health comorbidities) has fallen (by 49% from February 2012 to February 2013)
  - There has also been an increase in the share of ADHD claims with comorbidities and in the number of primary claims for other behavioral conditions (especially ODD & unspecified conduct disturbance)

- Analysis is pending to distinguish among three potential drivers of this trend:
  - Providers may be following more accurate diagnosis and coding practices and hence correctly coding comorbidities and distinguishing between ADHD and other behavioral health conditions
  - Providers may be changing their treatment patterns to better reflect efficient delivery of guideline-concordant care to patients correctly diagnosed with ADHD
  - Some providers may be changing coding patterns to avoid the episode model before it is rolled out to further behavioral health conditions including comorbidities

- Since the start of the performance period, the number of claims per ADHD-only patient has decreased by ~25%, with a shift seen in the mix of claims toward medication and away from physician visits and psychosocial treatments. This change in treatment patterns is aligned with guideline-concordant practice

- To date, few providers have submitted required certifications for quality assessment (240 certificates) or high-quality continuous care (1,825 certificates out of an estimated 18,000 existing ADHD-only patients), though the numbers are increasing. Also, few providers have certified that their patients are sub-optimally responding to medication and require additional (“level 2”) care (204 certificates)

Note: Based on preliminary analysis of episode performance and claims data available as of June 28, 2013

Among existing clients, drop in ADHD-only diagnosis appears driven by change in diagnosis/coding patterns not in clients no longer making claims

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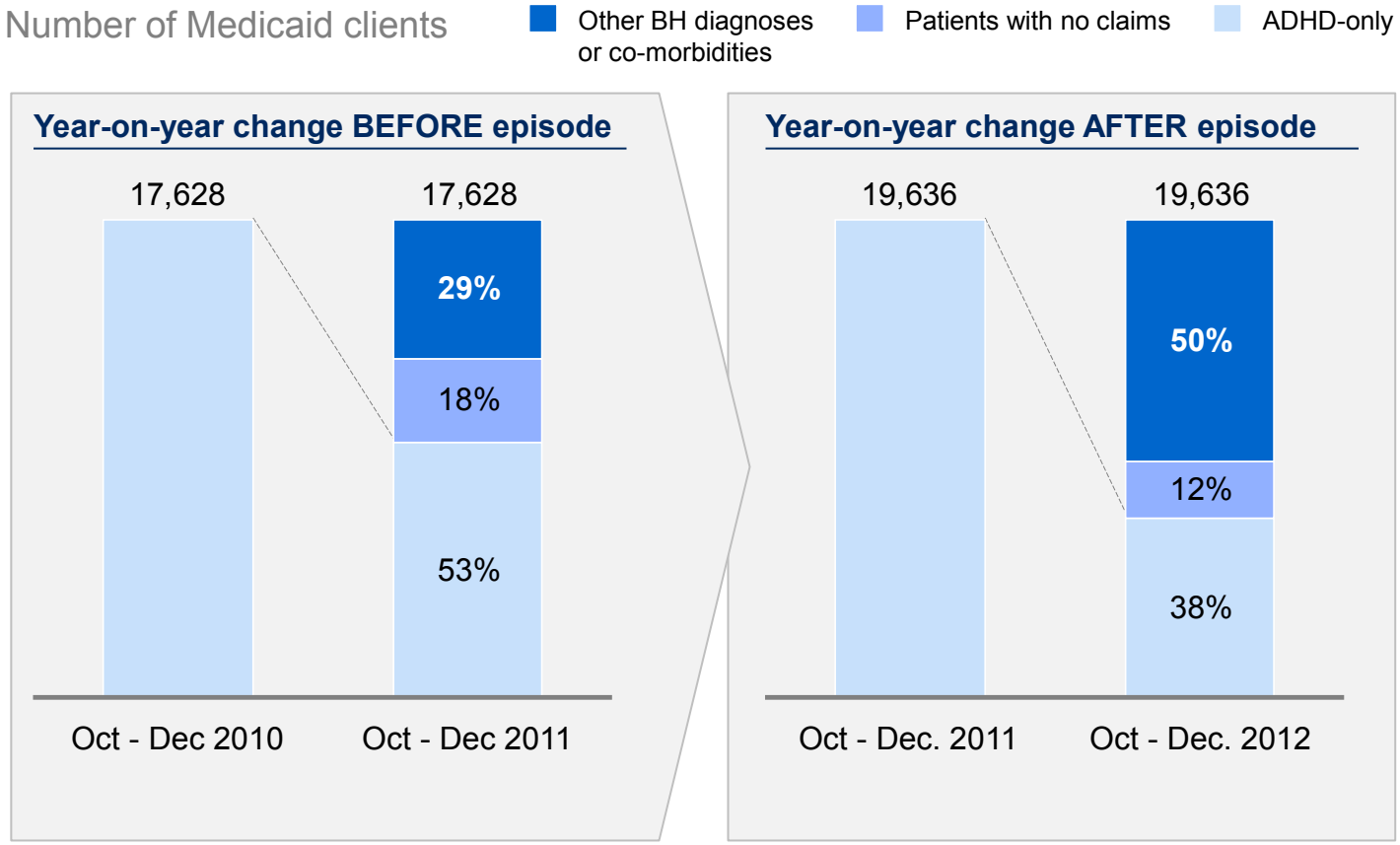
Year-on-year change in BH diagnosis coding for existing ADHD-only clients



Key takeaways

- % of clients no longer making any BH claim decreased compared with prior years
- Drop in ADHD only claims appears to be due to a shift in which diagnoses are coded[1]

1 Timing of increase in co-morbid claims coincides with some coding changes allowing for inclusion of co-morbidities – analysis is underway to understand the impact of the system changes on the results

Source: Medicaid claims data Oct 2010–Dec 2011 and Oct 2011-Dec 2012

Shift in diagnosis/coding patterns is clearly evident from Medicaid claims data

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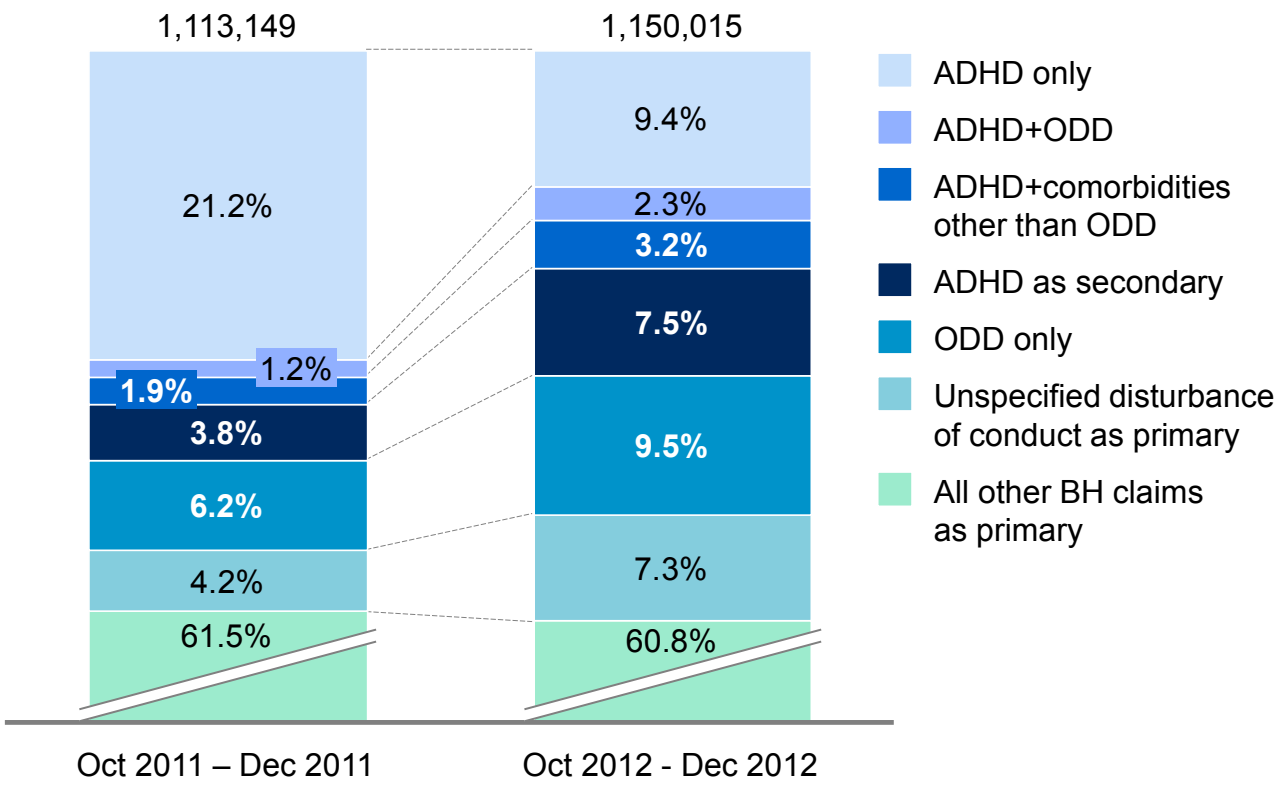
Comparison of diagnosis coding mix of BH Medicaid claims before and after episode launch[1]



Key takeaways

- Large drop in ADHD only claims was offset by increases in:
  - ODD only
  - Comorbid diagnoses
  - Unspecified diagnoses
  - ADHD as secondary

1 Includes all claims types e.g. (J (professional visits),S (inpatient), D (for pharmacy) and others;
2 Timing of increase in co-morbid claims coincides with some coding changes allowing for inclusion of co-morbidities;

Source: Medicaid claims data Oct 2011– Dec 2011 and Oct 2012–Dec 2012

Among new patients, the drop in ADHD only claims was more pronounced among Behavioral Health Providers than among PCPs

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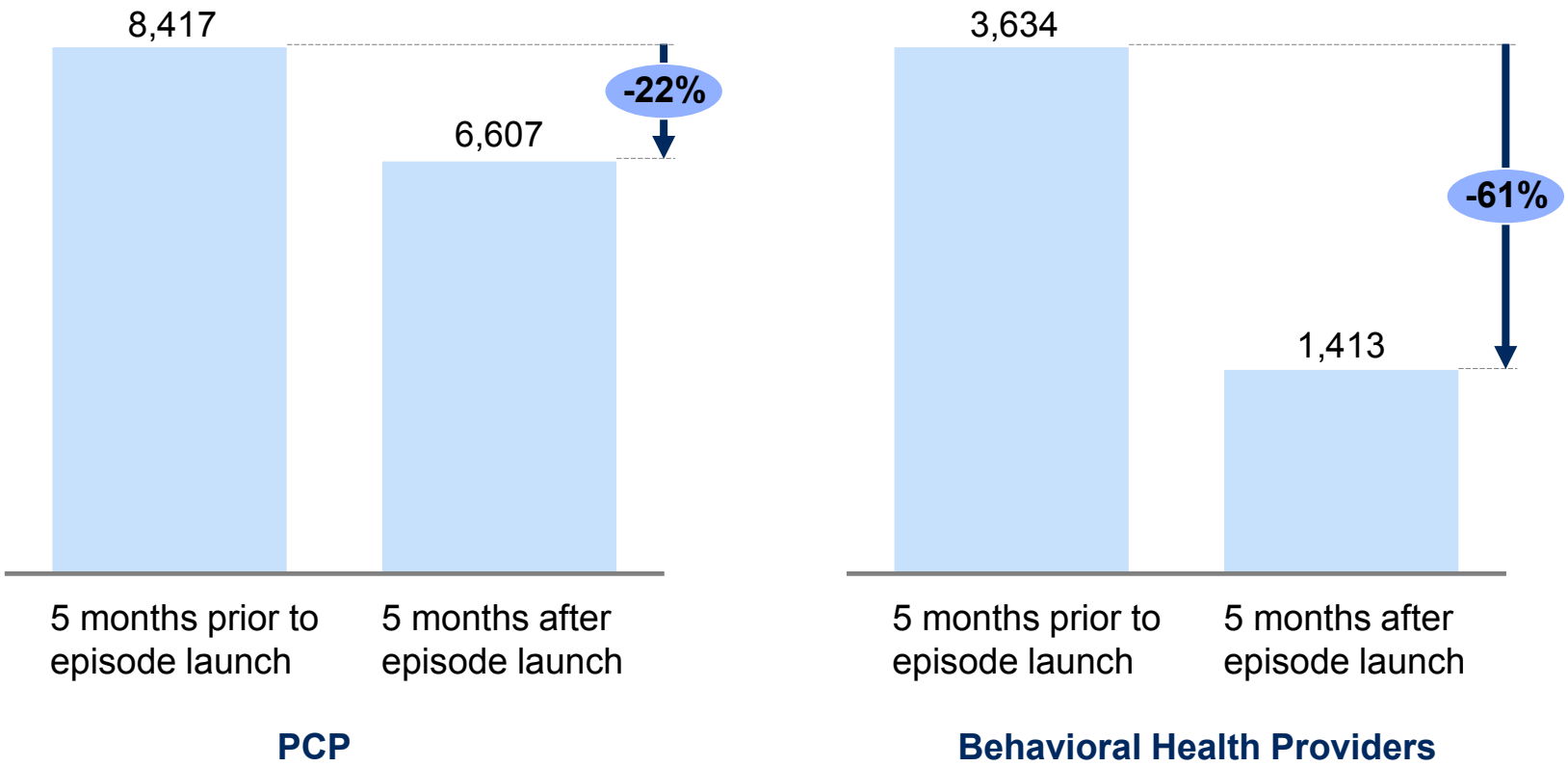
Comparison of change in new patients diagnosed with ADHD before and after episode launch[1]

Total # new patients diagnosed with ADHD only



1 Patients calculated using all claims types e.g. (J (professional visits),S (inpatient), D (for pharmacy) and others;
2 Timing of increase in co-morbid claims coincides with some coding changes allowing for inclusion of co-morbidities;

Source: Medicaid claims data Oct 2010– Dec 2012

Shift in diagnosis/coding patterns was evident among PCPs, but was primarily driven by Behavioral Health Providers

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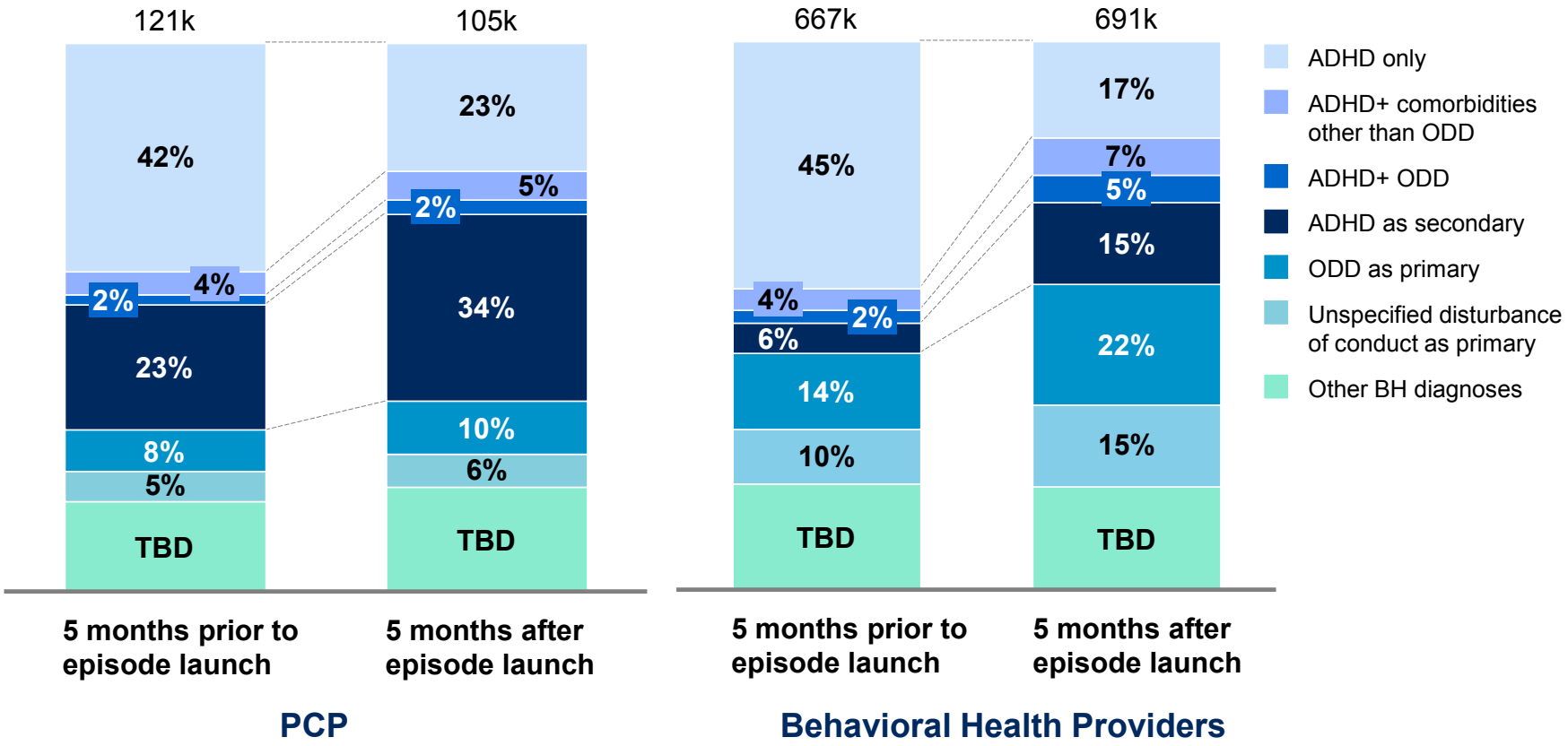
Comparison of diagnosis coding mix of BH Medicaid claims before and after episode launch[1]

Total #of claims, % of total



1 Includes all claims types e.g. (J (professional visits),S (inpatient), D (for pharmacy) and others;
2 Timing of increase in co-morbid claims coincides with some coding changes allowing for inclusion of co-morbidities;

Source: Medicaid claims data Oct 2010– Dec 2012

As number of claims with ADHD primary diagnosis fell, number of claims with ADHD as secondary diagnosis more than doubled

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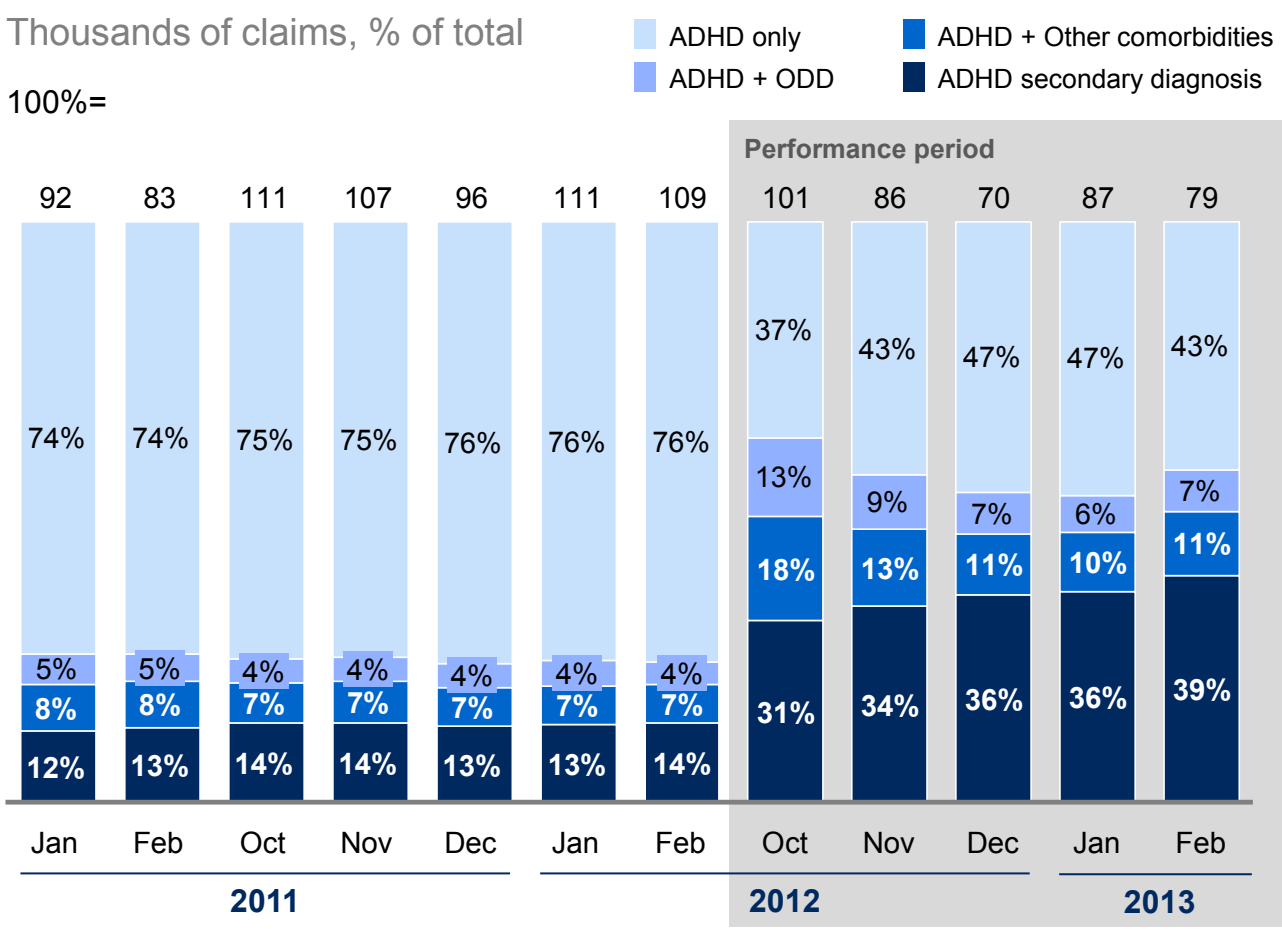
All Medicaid BH claims that include an ADHD diagnosis



Key takeaways

- There was a sharp increase in ADHD as a secondary diagnosis following episode launch as with co-morbid diagnoses
- ADHD as a secondary diagnosis has continued to grow month-on-month since episode launch

1 ADHD primary is defined as any claim with ADHD as primary diagnosis, secondary claims is defined as any claim with the following diagnoses as primary claim: ODD, Unspecified hyperkinetic syndrome of CHI, Unspecified disturbance of conduct, Unspecified episodic mood disorder, Depressive disorder, not elsewhere class, Adjustment reaction with mixed disturbance, Adjustment reaction with mixed emotional, Disthymic disorder, Post traumatic stress disorder, Generalized anxiety disorder, Adjustment reaction with anxious mood, Conduct disorder, adolescent onset type

Source: Medicaid claims data Jan 2011–Feb 2013

More providers (seeing more clients) have reduced their coding persistency for professional claims after episode launch

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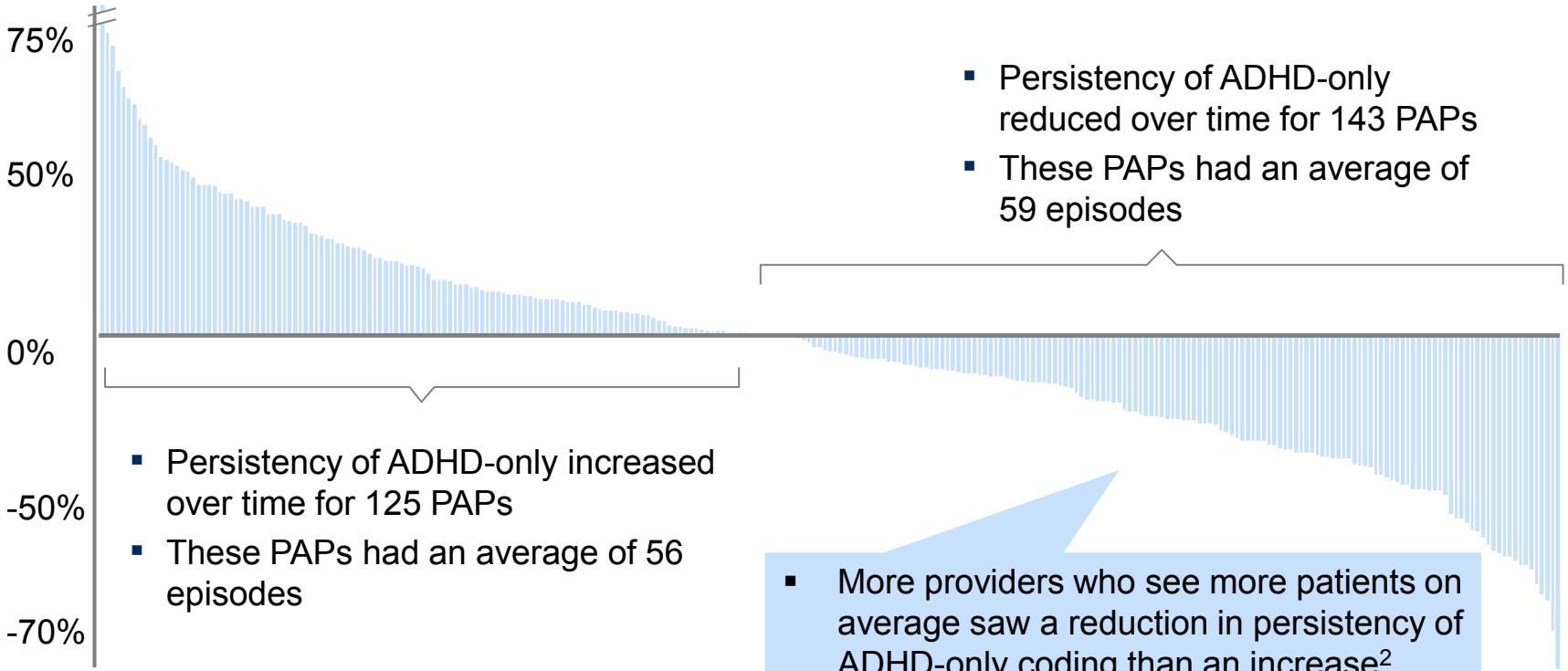
Change in persistency between Q4 2010/2011 and Q4 2011/2012 by provider[3]

Change in persistency (percentage points)[1] between Q4 2010/2011 and Q4 2011/2012



1 Percent of patients that were persistently diagnosed as ADHD only = (# of patients with ADHD-only diagnosis this quarter AND last quarter) / (# of patients with ADHD-only diagnosis last quarter)
2 Five PAPs saw no change in persistency
3 Timing of increase in co-morbid claims coincides with some system changes allowing for inclusion of co-morbidities – Further analysis underway
SOURCE: Medicaid claims data Oct 2010-Dec 2010, Oct 2011-Dec 2011 and Oct 2012-Dec 2012