



Division of
**Health Care
Finance & Administration**

Health Care
Innovation Initiative

A large, light gray graphic consisting of a circle containing three five-pointed stars arranged in a triangular pattern.

Executive Summary

Attention Deficit and Hyperactivity Disorder Episode
Corresponds with DBR and Configuration file V1.3

Updated: February 1, 2017

OVERVIEW OF AN ATTENTION DEFICIT AND HYPERACTIVITY DISORDER EPISODE

The attention deficit and hyperactivity disorder episode revolves around patients who are diagnosed with attention deficit and hyperactivity disorder (ADHD). The trigger event is either a professional claim with a primary diagnosis for ADHD, or a professional claim with a primary diagnosis for ADHD specific symptoms and a secondary diagnosis code for ADHD, along with a procedure code that is for assessments and testing, case management, E&M and medication management, or therapy visits. Only care with a primary diagnosis of ADHD, or a primary diagnosis of ADHD specific symptoms and a secondary diagnosis from among the ADHD trigger codes, as well as a specific list of medications, are included in the episode spend. The quarterback, also called the principal accountable provider or PAP, is the provider with the plurality of visits for ADHD during the episode window. The ADHD episode begins on the day of the triggering visit and extends for an additional 179 days.

CAPTURING SOURCES OF VALUE

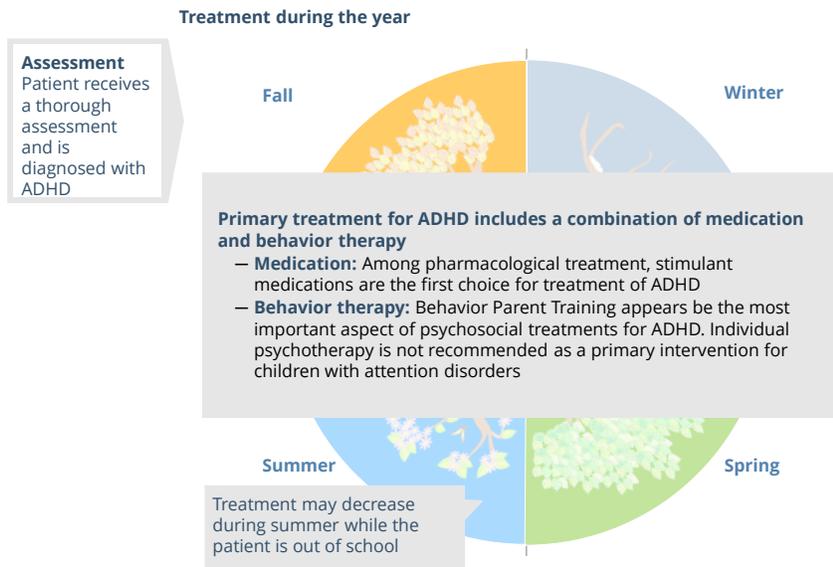
Providers have multiple opportunities during an ADHD episode to improve the quality and cost of care. Example sources of value include the effective use of assessments to ensure the diagnosis is accurate and the age-appropriateness of treatment. Additionally, providers can make appropriate choices regarding the use of medications. The provider can also bring about a reduction of unnecessary repeated performance testing, neuropsychological testing, EKGs, and/or lab work. Furthermore, because this is a chronic condition, there is opportunity for providers to ensure that the reduction of treatment in the summer only happens in clinically appropriate cases.

To learn more about the episode's design, please reference the following documents on our website at www.tn.gov/hcfa/topic/episodes-of-care:

- *Detailed Business Requirements: Complete technical description of the episode*
<http://www.tn.gov/assets/entities/hcfa/attachments/AttentionDeficitAndHyperactivityDisorder.pdf>
- *Configuration File: Complete list of codes used to implement the episode*
<http://www.tn.gov/assets/entities/hcfa/attachments/ADHD.xlsx>

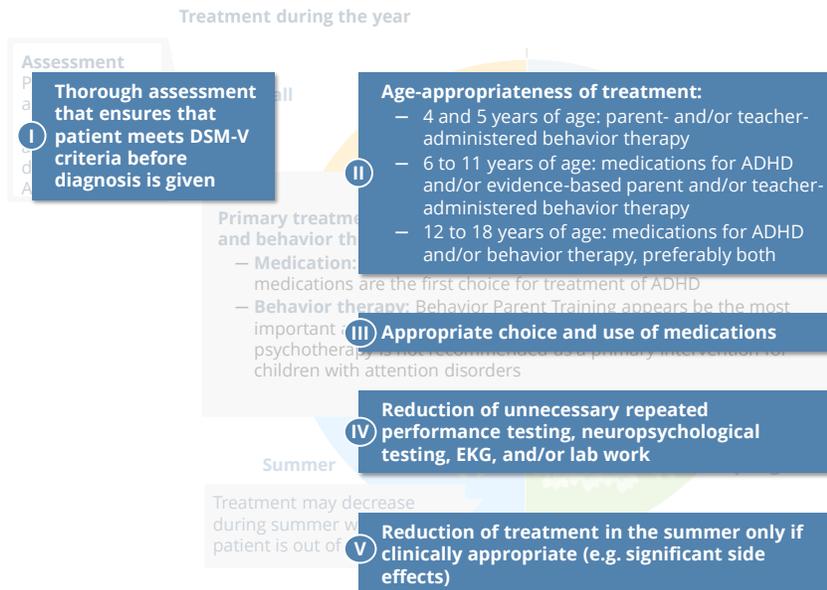
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Illustrative Patient Journey



Source: Clinical experts, TDMHSAS (2013). *Best Practice Guidelines: Attention Deficit Hyperactivity Disorder in Children and Adolescents*

Potential Sources of Value



Source: Clinical experts, TDMHSAS (2013). *Best Practice Guidelines: Attention Deficit Hyperactivity Disorder in Children and Adolescents*

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ASSIGNING ACCOUNTABILITY

The quarterback of the episode is the specific health care provider deemed to have the greatest accountability for the quality and cost of care for the patient. To state it differently, the quarterback is the provider who has the greatest ability to influence all of the health care delivered in a given episode. For the ADHD episode, the quarterback is the provider with the plurality of visits for ADHD during the episode window. The contracting entity or tax identification number with the plurality of ADHD visits will be used to identify the quarterback.

MAKING FAIR COMPARISONS

The episode model is designed to be fair to providers and incentivize best practices without penalizing providers who care for sicker patients. As such, important aspects of the model are:

- Inclusion of only the cost of services and medications that are related to the ADHD episode in calculation of episode spend.
- Exclusion of episodes when clinical circumstances create the likelihood that the case will deviate substantially from the typical care path or when claims data is likely to be incomplete.
- Risk adjusting episode spend to account for the cost of more complicated patients.

The ADHD episode has no pre-trigger window. During the trigger window the following services are included in episode spend: services with a primary diagnosis for ADHD, services with a primary diagnosis for a symptom of ADHD and a secondary diagnosis for ADHD, and pharmacy claims with HIC3 codes for specific medications. The ADHD episode has no post-trigger window.

Some exclusions apply to any type of episode, i.e., are not specific to an ADHD episode. For example, an episode would be excluded if more than one payer was involved in a single episode of care, if the patient was not continuously insured by the payer during the duration of the episode, or if the patient had a discharge status of 'left against medical advice'. Other examples of exclusion criteria specific to the ADHD episode include a patient who has autistic disorder or schizophrenia.

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These patients have significantly different clinical courses that the episode does not attempt to risk adjust. Furthermore, there may be some factors with a low prevalence or significance that would make accurate risk adjustment difficult and may be used to exclude patients completely instead of adjusting their costs.

For the purposes of determining a quarterback's cost of each episode of care, the actual reimbursement for the episode will be adjusted to reflect risk factors captured in recent claims data in order to be fair to providers caring for more complicated patients. Examples of patient factors likely to lead to the risk adjustment of ADHD episodes include cardiac conditions or learning disabilities. Over time, a payer may adjust risk factors based on new data.

MEASURING QUALITY

The episode reimbursement model is designed to reward providers who deliver cost effective care AND who meet certain quality thresholds. A quarterback must meet or exceed all established benchmarks for any quality metric tied to gain sharing in order to be eligible to receive monetary rewards from the episode model. Other quality metrics may be tracked and reported for quality improvement purposes but may not be tied directly to gain sharing.

The quality metric linked to gain sharing for the ADHD episode is:

- **Minimum care requirement:** Percentage of valid episodes that meet the minimum care requirement. The minimum care requirement is set at 5 visits/claims during the episode window. These may be a combination of E&M and medication management visits, therapy visits, level I case management visits, or pharmacy claims for treatment of ADHD (higher rate indicative of better performance).

The quality metrics that will be tracked and reported to providers but that are not tied to gain sharing are:

- **Utilization of E&M and medication management:** Average number of E&M and medication management visits per valid episode (rate not indicative of performance).
- **Utilization of therapy:** Average number of therapy visits per valid episode

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- **Utilization of level I case management:** Average number of level I case management visits per valid episode (rate not indicative of performance).
- **Utilization of medication by age group:** Percentage of valid episodes with medication by age group (4 and 5, 6 to 11, and 12 to 20) (rate not indicative of performance).
- **Follow-up:** Percentage of valid episodes for which the patient has an E&M and medication management, therapy, or level I case management visit within 30 days of the triggering visit (higher rate indicative of better performance).

It is important to note that quality metrics are calculated by each payer on a per quarterback basis across all of a quarterback's episodes covered by that payer. Failure to meet all quality benchmarks tied to gain sharing will render a quarterback ineligible for gain sharing with that payer for the performance period under review.