ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services

Program Development & Quality Assurance

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480 ·

June 8, 2012

Ms. Donna Davis
Committee on Administrative Rules and Regulations
Arkansas Legislative Council
Room 315 State Capitol Building
Little Rock, AR 72201

Dear Ms. Davis:

Enclosed are two copies of the Questionnaire with the proposed rule regarding the following: Episode performance payments for Ambulatory URI, ADHD and Perinatal care.

If you have any questions or comments, please address them to Division of Medical Services, P. O. Box 1437, Mail Slot S295, Little Rock, AR 72203-1437.

Sincerely,

Andy Allison MS

Andrew Allison, PhD
Director

AA/bam
Enclosure

QUESTIONNAIRE FOR FILING PROPOSED RULES AND REGULATIONS WITH THE ARKANSAS LEGISLATIVE COUNCIL AND JOINT INTERIM COMMITTEE

DEPARTMENT/AGENCY Department of Human Services
DIVISION Division of Medical Services
DIVISION DIRECTOR Andrew Allison, PhD
CONTACT PERSON Robert Nix
ADDRESS P.O Box 1437, Slot S295, Little Rock, AR 72203
PHONE NO. 682-8362 **FAX NO.** 682-2480 **E-MAIL** robert.nix@arkansas.gov
NAME OF PRESENTER AT COMMITTEE MEETING Marilyn Strickland
PRESENTER E-MAIL marilyn.strickland@arkansas.gov

INSTRUCTIONS

A. Please make copies of this form for future use.
B. Please answer each question completely using layman terms. You may use additional sheets, if necessary.
C. If you have a method of indexing your rules, please give the proposed citation after "Short Title of this Rule" below.
D. Submit two (2) copies of this questionnaire and financial impact statement attached to the front of two (2) copies of the proposed rule and required documents. Mail or deliver to:

Donna K. Davis
Administrative Rules Review Section
Arkansas Legislative Council
Bureau of Legislative Research
Room 315, State Capitol
Little Rock, AR 72201

****

1. What is the short title of this rule?

   Episode performance payments for Ambulatory URI, ADHD and Perinatal care

2. What is the subject of the proposed rule?

   To create an Episode of Care Medicaid manual, update Section 1 to include information regarding Arkansas Medicaid Episodes of Care as well as the Arkansas Medicaid State Plan.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ___ No __X__.
   If yes, please provide the federal rule, regulation, and/or statute citation.

4. Was this rule filed under the emergency provisions of the Administrative Procedure Act? Yes___ No__X__.

   If yes, what is the effective date of the emergency rule? _____

   When does the emergency rule expire? _____

   Will this emergency rule be promulgated under the permanent provisions of the Administrative Procedure Act? Yes____ No__

5. Is this a new rule? Yes X No ____ If yes, please provide a brief summary explaining the regulation.

   Does this repeal an existing rule? Yes____ No X If yes, a copy of the repealed rule is to be included with your completed questionnaire. If it is being replaced with a new rule, please provide a summary of the rule giving an explanation of what the rule does.

   Is this an amendment to an existing rule? Yes____ No X If yes, please attach a mark-up showing the changes in the existing rule and a summary of the substantive changes. **Note: The summary should explain what the amendment does, and the mark-up copy should be clearly labeled "mark-up."**

6. Cite the state law that grants the authority for this proposed rule? If codified, please give Arkansas Code citation.

   Arkansas Statute 20-76-201

7. What is the purpose of this proposed rule? Why is it necessary?

   The purpose of the proposed rule is to establish an Episode of Care Manual for Arkansas Medicaid as well as insert general information regarding Episodes of Care into Section 1 of the current Arkansas Medicaid manuals. Medicaid has established a payment improvement initiative to incentivize improved care quality, efficiency, and economy. The program uses episode-based data to evaluate the quality, efficiency, and economy of care delivered in the course of the episode, and to apply payment incentives.

   The proposed rule is necessary so that providers are aware of Arkansas Medicaid requirements and expectations involving Episodes of Care.

8. Please provide the address where this rule is publicly accessible in electronic form via the Internet as required by Arkansas Code § 25-19-108(b).

   https://www.medicaid.state.ar.us/InternetSolution/general/comment/comment.aspx

9. Will a public hearing be held on this proposed rule? Yes X No ____.
   If yes, please complete the following:
   Date: July 5, 2012
   Time: 10:00 a.m.
   Place: Blue Flame Room, 400 East Capitol, Little Rock

10. When does the public comment period expire for permanent promulgation? (Must provide a date.)

    July 10, 2012

11. What is the proposed effective date of this proposed rule? (Must provide a date.)

    October 1, 2012

12. Do you expect this rule to be controversial? Yes____ No X If yes, please explain.

13. Please give the names of persons, groups, or organizations that you expect to comment on these rules? Please provide their position (for or against) if known.

    Medical associations, interested providers, and advocacy organizations. Their positions for or against is not known at this time.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Department of Human Services
DIVISION Division of Medical Services
PERSON COMPLETING THIS STATEMENT Randy Helms
TELEPHONE NO. 682-1857 **FAX NO.** 682-2480 **EMAIL:** randy.helms@arkansas.gov

To comply with Act 1104 of 1995, please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE – Episode performance payments for Ambulatory URI, ADHD and Perinatal care

1. Does this proposed, amended, or repealed rule have a financial impact?
   Yes X No _____.

2. Does this proposed, amended, or repealed rule affect small businesses?
   Yes X No _____.

   If yes, please attach a copy of the economic impact statement required to be filed with the Arkansas Economic Development Commission under Arkansas Code § 25-15-301 et seq.

3. If you believe that the development of a financial impact statement is so speculative as to be cost prohibited, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please give the incremental cost for implementing the rule. Please indicate if the cost provided is the cost of the program.

Current Fiscal Year		Next Fiscal Year	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	
Total		Total	

5. What is the total estimated cost by fiscal year to any party subject to the proposed, amended, or repealed rule? Identify the party subject to the proposed rule and explain how they are affected.

Current Fiscal Year	Next Fiscal Year

6. What is the total estimated cost by fiscal year to the agency to implement this rule? Is this the cost of the program or grant? Please explain. **(The Medicaid program projects program savings resulting from the Healthcare Payment Improvement Initiative in the following amounts)**

Current Fiscal Year (2013)	Next Fiscal Year (2014)
($ 1,325,884) State	($ 2,735,028) State
($ 3,118,916) Federal	($ 6,598,434) Federal
($ 4,444,800) Total Savings	($ 9,333,462) Total Savings

ECONOMIC IMPACT STATEMENT
(As Required under Arkansas Code § 25-15-301)

Department: Arkansas Department of Human Services
Division: Medical Services
Person Completing this Statement: Randy Helms
Telephone Number: 501-682-1857 **Fax Number:** 501-682-3889
EMAIL: Randy.Helms@Arkansas.gov

Short Title of this Rule: Episode performance payments for Ambulatory URI, ADHD and Perinatal care

(1) The type or types of small businesses that will be directly affected by the proposed rule, bear the cost of the proposed rule, or directly benefit from the proposed rule.

Health Care providers providing services for conditions covered under episodes included in the Arkansas Health Care Payment Improvement Initiative.

(2) A description of how small businesses will be adversely affected.

Some health care providers may benefit from the episode performance payment model, while those providing services that do not meet certain cost and quality standards will see reduced provider revenue. Impact to any individual provider will depend on the provider's behavior and performance.

(3) A reasonable determination of the dollar amounts the proposed rule will cost small businesses in terms of fees, administrative penalties, reporting, recordkeeping, equipment, construction labor, professional services, revenue loss, or other costs associated with compliance.

Providers will incur some small additional administrative expense, limited to once-yearly input of several questions for each ADHD client. No additional incremental costs to providers are expected. The net revenue impact to any individual provider will depend on their current standard of care and any improvement they make.

(4) A reasonable determination of the dollar amounts of the costs to the agency of implementing the proposed rule, as well as the financial benefit to the agency of implementing the rule.

The Department projects savings resulting from implementation of this initiative to be $9,333,462 in SFY 2014. 2014 is the first year that the full impact of this initiative would be realized.

(5) Whether and to what extent alternative means exist for accomplishing the objectives of the proposed rule that might be less burdensome to small businesses and why such alternatives are not being proposed.

Not Applicable

(6) A comparison of the proposed rule with federal and state counterparts.

Not Applicable

Summary for
Episode performance payments for Ambulatory URI, ADHD and Perinatal care

Effective October 1, 2012, Arkansas Medicaid proposes to establish a payment improvement initiative to incentivize improved care quality, efficiency, and economy. The program uses episode-based data to evaluate the quality, efficiency, and economy of care delivered in the course of the episode, and to apply payment incentives. The proposed rule will establish an Episode of Care Manual for Arkansas Medicaid, insert general information regarding Episodes of Care into Section 1 of the current Arkansas Medicaid manuals as well as the Arkansas Medicaid State Plan.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services

Program Development & Quality Assurance

P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

TO: **Arkansas Medicaid Health Care Providers – All Providers**

DATE: **October 1, 2012**

SUBJECT: **Provider Manual Update Transmittal Secl-3-12**

REMOVE		INSERT	
Section	**Date**	**Section**	**Date**
___	___	180.000	___
___	___	181.000	10-1-12

Explanation of Updates

Section 180.000 is added as the new Episodes of Care section heading.

Section 181.000 is added to describe the new payment improvement initiative for Arkansas Medicaid providers.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the HP Enterprise Services Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at 501-682-6453 (Local); 1-800-482-5850, extension 2-6453 (Toll-Free) or to obtain access to these numbers through voice relay, 1-800-877-8973 (TTY Hearing Impaired).

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Andrew Allison, PhD
Director

TOC required

180.000 EPISODES OF CARE

181.000 INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY AND ECONOMY 10-1-12

A. Definitions

1. An "episode" refers to a defined collection of related Medicaid-covered health care services provided to a specific Medicaid beneficiary.
2. An "episode type" is defined by a diagnosis, health care intervention, or condition during a specific timeframe (or performance period).
3. "Thresholds" are the upper and lower reimbursement benchmarks for an episode of care.

B. Medicaid has established a payment improvement initiative ("payment improvement program") to incentivize improved care quality, efficiency and economy. The program uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode, and to apply payment incentives. **Please refer to the Episodes of Care Medicaid Manual for information about specific episodes.**

C. The payment improvement program is separate from, and does not alter, current methods for reimbursement.

D. The payment improvement program promotes efficiency, economy and quality of care by rewarding high-quality care and outcomes, encouraging clinical effectiveness, promoting early intervention and coordination to reduce complications and associated costs, and, when provider referrals are necessary, by encouraging referral to efficient and economic providers who furnish high-quality care.

E. All medical assistance provided in the delivery of care for an episode may be included in the determination of a supplemental payment incentive under the payment improvement program.

F. Payment incentives may be positive or negative. Incentive payments are calculated and made retrospectively after care has been completed and reimbursed in accordance with the published reimbursement methodology. Incentive payments are based on the aggregate of valid, paid claims across a provider's episodes and are not relatable to any individual provider claim for payment.

G. Medicaid establishes episode definitions, levels of supplemental incentive payments and appropriate quality measures based on evidence-based practices. To identify evidence-based practices, Medicaid shall consider clinical information furnished by Arkansas providers of the care and services typically rendered during the episode of care, and may also consider input from one or more quality improvement organizations ("QIO's") or QIO-like entities, peer-reviewed medical literature, or any combination thereof.

H. Principal Accountable Providers

The principal accountable provider(s) (PAPs) for each episode is/are identified in the section defining the episode. In some cases, Medicaid may identify PAPs after an episode is complete using algorithms described in the episode definition.

I. Supplemental Payment Incentives

For each PAP for each applicable episode type:

1. Performance will be aggregated and assessed over a specified period of time ("performance period"). For each PAP, the average reimbursement across all relevant episodes completed during the performance period will be calculated, based on the set of services included in the episode definition published and made available to providers.
2. Some episodes may be excluded and reimbursement for some episodes may be adjusted in this calculation, based on clinical or other factors, as described in the definition of each episode.
3. The average adjusted reimbursement of all episodes for the PAP during the performance period will be compared to thresholds established by Medicaid with advice from providers.
4. If the average adjusted episode reimbursement is lower than the commendable threshold and the PAP has documented that the quality requirements established by Medicaid for each episode type have been met, Medicaid will make a positive supplemental payment to the PAP. This payment will be equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation and multiplied by a gain sharing percentage for the episode. Where necessary, a gain sharing limit will be established to avoid incentives for underutilization. PAPs with average adjusted episode reimbursement lower than the gain sharing limit will receive a supplemental payment calculated as though their average adjusted episode reimbursement were equal to the gain sharing limit.
5. If the average episode reimbursement is higher than the acceptable threshold, the PAP will incur a negative supplemental payment. This payment to Medicaid will be equal to the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation and multiplied by a risk sharing percentage defined by Medicaid for the episode.

J. Principles for determining "thresholds"

1. The threshold process aims to incentivize high-quality clinical care delivered efficiently, and to consider several factors including the potential to improve patient access, the impact on provider economics and the level and type of practice pattern changes required for performance improvement.
2. The acceptable threshold is set such that average cost per episode above the acceptable threshold reflects unacceptable performance, which could result from a large variation from typical performance without clinical justification (e.g., individual provider variation) or from system-wide variance from widely accepted clinical standards.
3. The commendable threshold is set such that outperforming the commendable threshold represents quality care provided at a lower total reimbursement, which would result from care at meaningfully better than current average reimbursement in Arkansas, consistent with good medical outcomes. Medicaid may take into consideration what a clinically feasible target would be, as demonstrated by historical reimbursement variance in Arkansas.
4. The gain-sharing limit is set to avoid the risk of incentivizing care delivery at a cost that could compromise quality.
5. The gain and risk sharing percentages aim to recognize required provider investment in practice change and will be set at a sustainable level for Medicaid.

K. Outlier Patient Exclusions

Calculation of average adjusted episode reimbursement for each PAP will exclude outlier patients who have extraordinarily high risk/severity so that one or a few cases do not meaningfully misrepresent a provider's performance across the provider's broader patient population.

L. Provider-level adjustments

1. Supplemental payment incentives for each PAP take into account provider-level adjustments, which may include stop-loss provisions, adjustments for cost-based facilities, adjustments or exclusions for providers with low case volume or any combination thereof.

2. Medicaid has modeled the potential impact of thresholds on individual providers given historical treatment patterns, and under a number of scenarios representing meaningful improvement toward a more consistent provision of evidence-based care, and have identified a number of providers of ADHD services that far exceed clinical expectations in the volume of services reimbursed for Medicaid beneficiaries, and for whom reimbursement for ADHD services represents a significant percentage of total Medicaid reimbursement. To help sustain these providers for a reasonable period of transition as they seek to achieve acceptable levels of reimbursement and a clinically appropriate volume of services for the treatment of ADHD, Medicaid will apply stop-loss protection across all episodes for one year such that the net negative supplemental payment payable in a period (i.e., the total of all negative supplemental payments in a period minus the total of all positive supplemental payments in the same period) is capped at 10% of Medicaid reimbursement in the period.

3. Temporary stop-loss provisions may apply when necessary to ensure access to care.

4. Providers that receive cost-based or PPS-based reimbursement are reimbursed as specified in the corresponding provider manual(s), but are subject to positive and negative supplemental payment incentives in order to achieve statewide improvement in quality and efficiency. For episodes including services furnished by providers who receive at exceptional reimbursement levels, reimbursements attributed to PAPs for the purpose of calculating performance are computed as if the provider did not receive exceptional reimbursement.

5. Minimum case volume thresholds exclude from supplemental payment incentives those providers whose case volume includes too few cases to generate a robust measure of performance. Medicaid will set a minimum case volume for each episode type. PAPs who do not meet the minimum case volume for an episode type will not be eligible for positive or negative supplemental payments for that episode type.

M. Quality

1. For each episode type, there will be a set of quality metrics "to pass" and a set of quality metrics "to track." These quality metrics may be based on claims data or based on additional data specified by Medicaid, which PAPs will be required to report.

2. To quality for positive supplemental payments, PAPs must report all required data and meet specific thresholds for the quality metrics "to pass."

3. Providers who do not report data or who do not meet minimum quality thresholds may still incur negative supplemental payments if their average adjusted episode reimbursement exceeds the acceptable threshold.

N. Consideration of the aggregate cost and quality of care is not a retrospective review of the medical necessity of care rendered to any particular patient, nor is such consideration intended to supplant any retrospective review or other program integrity activity.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance
P.O. Box 1437, Slot S-295 · Little Rock, AR 72203-1437
501-682-8368 · Fax: 501-682-2480

TO: **Arkansas Medicaid Health Care Providers – Episodes of Care**

DATE: **October 1, 2012**

SUBJECT: **Provider Manual Update Transmittal EPISODE-New-12**

REMOVE		INSERT	
Section	**Date**	**Section**	**Date**
____	____	ALL	10-1-12

Explanation of Updates

The Episodes of Care provider policy manual is now available to participating Arkansas Medicaid providers as part of the new payment improvement initiative, which uses episode-based data to incentivize improved care quality, efficiency and economy.

If you have questions regarding this transmittal, please submit your inquiries through the public comment process.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Andrew Allison, PhD
Director

SECTION II - EPISODES OF CARE

CONTENTS

200.000 EPISODES OF CARE GENERAL INFORMATION

200.100 Episode Definition/Scope of Services 10-1-12

This section describes, for each episode type, the rules for determining the specific services included in a particular episode.

A. *Episode subtypes:* Episode types may be divided into two or more subtypes distinguished by more specific diagnostic criteria or other clinical information.

B. *Episode triggers:* Services or events that may initiate an episode.

C. *Episode duration:* The time before and after an episode trigger during which medical assistance may be included in an episode.

D. *Episode services:* Criteria used to determine which medical assistance is included or excluded in an episode when delivered within the episode duration. Services excluded

across all episode types are: nursing home claims, EPSDT claims and managed care claims and fees.

200.200 Principal Accountable Provider 10-1-12

This section specifies, for each episode type, the types of providers eligible to be Principal Accountable Providers (PAPs) for an episode type and the algorithm used to determine the PAP(s) for an individual episode. For each episode of care, providers designated as PAPs hold the main responsibility for ensuring that the episode is delivered with appropriate quality and efficiency.

200.300 Exclusions 10-1-12

This section describes, for each episode type, criteria to exclude an episode from calculation of a PAP's average performance.

Across all episode types, episodes are excluded for dual-eligible Medicaid and Medicare beneficiaries and for Third Party Liability (TPL) beneficiaries.

200.400 Adjustments 10-1-12

This section describes, for each episode type, adjustments to the reimbursement amount attributable to a PAP for the purpose of calculating performance and determining supplemental payment incentives.

Across all episode types, the reimbursement amount attributable to a PAP for facility claims for acute inpatient hospitalizations is adjusted to a per diem rate of $850.

200.500 Quality Measures 10-1-12

This section describes, for each episode type, the data and measures which Medicaid will track and evaluate to ensure provision of high-quality care for each episode type.

A. *Quality measures "to pass":* Measures for which a PAP must meet or exceed a minimum threshold in order to qualify for a full positive supplemental payment for that episode type.

B. *Quality measures "to track":* Measures for which a PAP's performance is not linked to supplemental payments. Performance on these measures may result in a program integrity review.

For quality measures "to pass" and quality measures "to track" that require data not available from claims, PAPs must submit data through the provider portal in order to qualify for a full positive supplemental payment.

200.600 Reimbursement Thresholds 10-1-12

This section describes, for each episode type, the specific values used to calculate positive or negative supplemental payments. This includes an acceptable threshold, a commendable threshold, a gain sharing limit and a risk sharing percentage.

200.700 Minimum Case Volume 10-1-12

This section describes, for each episode type, the minimum case volume required for a PAP to qualify for positive or negative supplemental payments. PAPs who do not meet the minimum case volume for an episode type will not be eligible for positive or negative supplemental payments for that episode type.

210.000 ACUTE AMBULATORY UPPER RESPIRATORY INFECTION (URI) EPISODES

210.100 Episode Definition/Scope of Services 10-1-12

A. *Episode subtypes:*

1. Acute Nonspecific URI
2. Acute Pharyngitis and similar conditions
3. Acute Sinusitis

B. *Episode trigger:*

Office visits, clinic visits or emergency department visits with a primary diagnosis of an Acute Ambulatory URI ("URI") that do not fall within the time window of a previous URI episode.

C. *Episode duration:*

Episodes begin on the day of the triggering visit and conclude after 21 days.

D. *Episode services:*

All services relating to the treatment of a URI within the duration of the episode are included. The following services are excluded:

1. Surgical procedures
2. Transport
3. Immunizations commonly administered for preventative care
4. Non-prescription medications

210.200 Principal Accountable Provider 10-1-12

The Principal Accountable Provider (PAP) for an episode is the first Arkansas Medicaid enrolled and qualified provider to diagnose a beneficiary with an Acute Ambulatory URI during an in-person visit within the time window for the episode.

210.300 Exclusions 10-1-12

Episodes meeting one or more of the following criteria will be excluded:

A. Children younger than 1 year of age

B. Beneficiaries with inpatient stays or hospital monitoring during the episode duration

C. Beneficiaries with surgical procedures related to the URI (tonsillectomy, adenoidectomy)

D. Beneficiaries with the following comorbidities diagnosed at least twice in the one year period before the episode end date: 1) asthma; 2) cancer; 3) chronic URI; 4) end-stage renal disease; 5) HIV and other immunocompromised conditions; 6) post-procedural state for transplants, pulmonary disorders, rare genetic diseases, and sickle cell anemia

E. Beneficiaries with the following comorbid diagnoses during the episode: 1) croup, 2) epiglottitis, 3) URI with obstruction, 4) pneumonia, 5) influenza, 6) otitis media

F. Beneficiaries who do not have continuous Medicaid enrollment for the duration of the episode

210.400 Adjustments 10-1-12

The reimbursement for the initial visit that is attributable to the PAP is normalized across different places of service (e.g., "Level 2" visits will count equally toward average reimbursement regardless of place of service). Reimbursements for the facility claim associated with the initial visit are not counted in the total reimbursements attributed to a PAP for calculation of performance.

Reimbursement attributed to the calculation of a PAP's performance for beneficiaries 10 and under is adjusted to reflect age-related variations in treatment using a multiplier determined by regression.

210.500 Quality Measures 10-1-12

A. *Quality measures "to pass":*

1. Frequency of strep testing for beneficiaries who receive antibiotics (for Acute Pharyngitis episode only) – must meet minimum threshold of 47%

B. *Quality measures "to track":*

1. Frequency of antibiotic usage
2. Frequency of multiple courses of antibiotics during one episode
3. Average number of visits per episode

210.600 Thresholds for Incentive Payments 10-1-12

A. *Acute Nonspecific URI*

1. The acceptable threshold is $67.00.
2. The commendable threshold is $46.00.
3. The gain sharing limit is $14.70.
4. The gain sharing percentage is 50%.
5. The risk sharing percentage is 50%.

B. *Acute Pharyngitis and similar conditions*

1. The acceptable threshold is $80.00.
2. The commendable threshold is $60.00.
3. The gain sharing limit is $14.70.
4. The gain sharing percentage is 50%
5. The risk sharing percentage is 50%.

C. *Acute Sinusitis*

1. The acceptable threshold is $87.00.
2. The commendable threshold is $68.00.
3. The gain sharing limit is $14.70.
4. The gain sharing percentage is 50%.
5. The risk sharing percentage is 50%.

210.700 Minimum Case Volume 10-1-12

The minimum case volume is 5 total cases for each episode subtype per 12 month period.

211.000 PERINATAL CARE EPISODES

211.100 Episode Definition/Scope of Services 10-1-12

A. *Episode trigger:*

A live birth on a facility claim

B. *Episode duration:*

Episode begins 40 weeks prior to delivery and ends 60 days after delivery

C. *Episode services:*

All medical assistance with a pregnancy-related ICD-9 diagnosis code is included. Medical assistance related to neonatal care is not included.

211.200 Principal Accountable Provider 10-1-12

For each episode, the Principal Accountable Provider (PAP) is the provider or provider group that performs the delivery.

211.300 Exclusions 10-1-12

Episodes meeting one or more of the following criteria will be excluded:

A. Limited prenatal care (i.e., pregnancy-related claims) provided between start of episode and 60 days prior to delivery

B. Delivering provider did not provide any prenatal services

C. Episode has no professional claim for delivery

D. Pregnancy-related conditions: amniotic fluid embolism, obstetric blood clot embolism, placenta previa, severe preeclampsia, multiple gestation ≥3, late effect complications of pregnancy/childbirth, puerperal sepsis, suspected damage to fetus from viral disease in mother

E. Comorbidities: cancer, cystic fibrosis, congenital cardiovascular disorders, DVT/pulmonary embolism, other phlebitis and thrombosis, end-stage renal disease, sickle cell, Type I diabetes

211.400 Adjustments 10-1-12

For the purposes of determining a PAP's performance, the total reimbursement attributable to the PAP is adjusted to reflect risk and/or severity factors captured in the claims data for each episode in order to be fair to providers with high-risk patients, to avoid any incentive for adverse selection of patients and to encourage high-quality, efficient care. Medicaid, with clinical input from Arkansas providers, will identify risk factors via literature, Arkansas experience and clinical expertise. Using standard statistical techniques and clinical review, risk factors will be tested for statistical and clinical significance to identify a reasonable number of factors that have meaningful explanatory power ($p < 0.01$) for predicting total reimbursement per episode. Some factors which have meaningful explanatory power may be excluded from the set of selected risk factors where necessary to avoid potential for manipulation through coding practices. Episode reimbursement attributable to a PAP for calculating average adjusted episode reimbursement are adjusted based on selected risk factors. Over time, Medicaid may add or subtract risk factors in line with new research and/or empirical evidence.

211.500 Quality Measures 10-1-12

A. *Quality measures "to pass":*

1. HIV screening – must meet minimum threshold of 80% of episodes
2. Group B streptococcus screening (GBS) – must meet minimum threshold of 80% of episodes
3. Chlamydia screening – must meet minimum threshold of 80% of episodes

B. *Quality measures "to track":*

1. Ultrasound screening
2. Screening for Gestational Diabetes
3. Screening for Asymptomatic Bacteriuria
4. Hepatitis B specific antigen screening
5. C-Section Rate

211.600 Thresholds for Incentive Payments 10-1-12

A. The acceptable threshold is $3,906.00.

B. The commendable threshold is $3,394.00.

C. The gain sharing limit is $2,000.00.

D. The gain sharing percentage is 50%.

E. The risk sharing percentage is 50%.

211.700 Minimum Case Volume 10-1-12

The minimum case volume is 5 total cases per 12 month period.

212.000 ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD) EPISODES

212.100 Episode Definition/Scope of Services 10-1-12

A. *Episode subtypes:*

1. Level I: Episode of care for an ADHD beneficiary with no behavioral health comorbid conditions and for whom no qualifying Severity Certification has been completed.
2. Level II: Episode of care for an ADHD beneficiary with no behavioral health comorbid conditions who has had an inadequate response to medication management. Providers must complete a Severity Certification through the provider portal to qualify beneficiaries for a Level II designation.

B. *Episode trigger:*

Level I subtype episodes are triggered by either two medical claims with a primary diagnosis of ADHD or a medical claim with a primary diagnosis of ADHD as well as a pharmacy claim for medication used to treat ADHD. Level II subtype episodes are triggered by a completed Severity Certification followed by either two medical claims with a primary diagnosis of ADHD or a medical claim with a primary diagnosis of ADHD as well as a pharmacy claim for medication used to treat ADHD.

C. *Episode duration:*

The standard episode duration is a 12-month period beginning at the time of the first trigger claim. A Level I episode will conclude at the initiation of a new Level II episode if a Severity Certification is completed during the 12-month period.

D. *Episode services:*

All claims with a primary diagnosis of ADHD as well as all medications indicated for ADHD or used in the treatment of ADHD.

Notwithstanding any other provisions in the provider manual, medical assistance included in an ADHD episode shall not be subject to prior authorization requirements.

212.200 Principal Accountable Provider 10-1-12

Determination of the Principal Accountable Provider (PAP) is based upon which provider is responsible for the largest number of claims within the episode.

If the provider responsible for the largest number of claims is a physician or an RSPMI provider organization, that provider is designated 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.

If the provider responsible for the largest number of claims is a licensed clinical psychologist operating outside of an RSPMI provider organization, that provider is a co-PAP with the physician or RSPMI provider providing the next largest number of claims within the episode. 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 co-PAP.

Where there are co-PAPs for an episode, the positive or negative supplemental payments are divided equally between the co-PAPs.

212.300 Exclusions 10-1-12

Episodes meeting one or more of the following criteria will be excluded:

A. Duration of less than 4 months

B. Small number of medical and/or pharmacy claims during the episode

C. Beneficiaries with any behavioral health comorbid condition

D. Beneficiaries age 5 or younger and beneficiaries age 18 or older at the time of the initial claim

212.400 Adjustments 10-1-12

Total reimbursement attributable to the PAP for episodes with a duration of less than 12 months will be scaled linearly to determine a reimbursement per 12-months for the purpose of calculating the PAP's performance.

PROPOSED

212.500 Quality Measures 10-1-12

A. *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

B. *Quality measures "to track":*

1. In order to track and evaluate selected quality measures, providers are asked to complete a "Quality Assessment" certification (for beneficiaries new to the provider) or a "Continuing Care" certification (for beneficiaries previously receiving services from the provider)
2. Percentage of episodes classified as Level II
3. Average number of physician visits/episode
4. Percentage of episodes with medication
5. Percentage of episodes certified as non-guideline concordant
6. Percentage of episodes certified as non-guideline concordant with no rationale

212.600 Thresholds for Incentive Payments **10-1-12**

A. *ADHD Level I*

1. The acceptable threshold is $2,223.
2. The commendable threshold is $1,547.
3. The gain sharing limit is $700.
4. The gain sharing percentage is 50%.
5. The risk sharing percentage is 50%.

B. *ADHD Level II*

1. The acceptable threshold is $7,112.
2. The commendable threshold is $5,403.
3. The gain sharing limit is $2,223.
4. The gain sharing percentage is 50%.
5. The risk sharing percentage is 50%.

212.700 Minimum Case Volume **10-1-12**

The minimum case volume is 5 total cases per 12 month period.

1. Inpatient Hospital Services (continued)

PROPOSED

(i) Supplemental Payment Incentives

For each PAP for each applicable episode type:

(1) Performance will be aggregated and assessed over a specified period of time ("performance period"). For each PAP, the average reimbursement across all relevant episodes completed during the performance period will be calculated, based on the set of services included in the episode definition published and made available to providers.

(2) Some episodes may be excluded and reimbursement for some episodes may be adjusted in this calculation, based on clinical or other factors, as described in definition of each episode.

(3) The average adjusted reimbursement of all episodes for the PAP during the performance period will be compared to thresholds established by Medicaid with advice from providers.

(4) If the average adjusted episode reimbursement is lower than the commendable threshold and the PAP has documented that the quality requirements established by Medicaid for each episode type have been met, Medicaid will make a positive supplemental payment to the PAP. This payment will be equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation and multiplied by a gain sharing percentage for the episode. Where necessary, a gain sharing limit will be established to avoid incentives for underutilization. PAPs with average adjusted episode reimbursement lower than the gain sharing limit will receive a supplemental payment calculated as though their average adjusted episode reimbursement were equal to the gain sharing limit.

(5) If the average episode reimbursement is higher than the acceptable threshold, the PAP will incur a negative supplemental payment. This payment to Medicaid will be equal to the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation and multiplied by a risk sharing percentage defined by Medicaid for the episode.

(j) Principles for determining "thresholds"

(1) The threshold process aims to incentivize high-quality clinical care delivered efficiently, and to consider several factors including the potential to improve patient access, the impact on provider economics, and the level and type of practice pattern changes required for performance improvement.

(2) The acceptable threshold is set such that underperforming the acceptable threshold reflects unacceptable performance, which could result from a large variation from typical performance without clinical justification (e.g., individual provider variation) or from system-wide variance from widely accepted clinical standards.

(3) The commendable threshold is set such that outperforming the commendable threshold represents quality care provided at a lower total reimbursement, which would result from care at meaningfully better than current average reimbursement in Arkansas, consistent with good medical outcomes. Medicaid may take into consideration what a clinically feasible target would be, as demonstrated by historical reimbursement variance in Arkansas.

1. Inpatient Hospital Services (continued)

PROPOSED

(4) The gain-sharing limit is set to avoid the risk of incentivizing care delivery at a cost that could compromise quality.

(5) The gain and risk sharing percentages aim to recognize required provider investment in practice change and will be set at a sustainable level for Medicaid.

(k) Outlier Patient Exclusions

Calculation of average adjusted episode reimbursement for each PAP will exclude outlier patients who have extraordinarily high risk/severity so that one or a few cases do not meaningfully misrepresent a provider's performance across the provider's broader patient population.

(l) Provider-level adjustments

(1) Supplemental payment incentives for each PAP take into account provider-level adjustments, which may include stop-loss provisions, adjustments for cost-based facilities, adjustments or exclusions for providers with low case volume, or any combination thereof.

(2) Medicaid has modeled the potential impact of thresholds on individual providers given historical treatment patterns, and under a number of scenarios representing meaningful improvement towards a more consistent provision of evidence-based care, and have identified a number of providers of ADHD services that far exceed clinical expectations in the volume of services reimbursed for Medicaid beneficiaries, and for whom reimbursement for ADHD services represents a significant percentage of total Medicaid reimbursement. To help sustain these providers for a reasonable period of transition as they seek to achieve acceptable levels of reimbursement and a clinically appropriate volume of services for the treatment of ADHD, Medicaid will apply stop-loss protection across all episodes for one year such that the net negative supplemental payment payable in a period (i.e., the total of all negative supplemental payments in a period minus the total of all positive supplemental payments in the same period) is capped at 10% of Medicaid reimbursement in the period.

(3) Temporary stop-loss provisions may apply when necessary to ensure access to care.

(4) Providers that receive cost-based or PPS-based reimbursement are reimbursed as specified in the corresponding provider manual(s), but are subject to positive and negative supplemental payment incentives in order to achieve statewide improvement in quality and efficiency. For episodes including services furnished by providers who receive at exceptional reimbursement levels, reimbursements attributed to PAPs for the purpose of calculating performance are computed as if the provider did not receive exceptional reimbursement.

(5) Minimum case volume thresholds exclude from supplemental payment incentives those providers whose case-volume includes too few cases to generate a robust measure of performance. Medicaid will set a minimum case volume for each episode type. PAPs who do not meet the minimum case volume for an episode type will not be eligible for positive or negative supplemental payments for that episode type.

1. Inpatient Hospital Services (continued)

(n) Consideration of the aggregate cost and quality of care is not a retrospective review of the medical necessity of care rendered to any particular patient, nor is such consideration intended to supplant any retrospective review or other program integrity activity.

PROPOSED

2.a. Outpatient Hospital Services (continued)

PROPOSED

INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

(a) Definitions

(1) An "episode" refers to a defined collection of related Medicaid-covered health care services provided to a specific Medicaid beneficiary.
(2) An "episode type" is defined by a diagnosis, health care intervention, or condition during a specific timeframe (or performance period).
(3) "Thresholds" are the upper and lower reimbursement benchmarks for an episode of care.

(b) Medicaid has established a payment improvement initiative ("payment improvement program") to incentivize improved care quality, efficiency, and economy. The program uses episode-based data to evaluate the quality, efficiency, and economy of care delivered in the course of the episode, and to apply payment incentives. **Please refer to the Episodes of Care Medicaid Manual for information about specific episodes.**

(c) The payment improvement program is separate from, and does not alter, current methods for reimbursement.

(d) The payment improvement program promotes efficiency, economy, and quality of care by rewarding high-quality care and outcomes, encouraging clinical effectiveness, promoting early intervention and coordination to reduce complications and associated costs, and, when provider referrals are necessary, by encouraging referral to efficient and economic providers who furnish high-quality care.

(e) All medical assistance provided in the delivery of care for an episode may be included in the determination of a supplemental payment incentive under the payment improvement program.

(f) Payment incentives may be positive or negative. Incentive payments are calculated and made retrospectively after care has been completed and reimbursed in accordance with the published reimbursement methodology. Incentive payments are based on the aggregate of valid, paid claims across a provider's episodes and are not relatable to any individual provider claim for payment.

(g) Medicaid establishes episode definitions, levels of supplemental incentive payments, and appropriate quality measures based on evidence-based practices. To identify evidence-based practices, Medicaid shall consider clinical information furnished by Arkansas providers of the care and services typically rendered during the episode of care, and may also consider input from one or more quality improvement organizations ("QIO's") or QIO-like entities, peer-reviewed medical literature, or any combination thereof.

(h) Principal Accountable Providers

The principal accountable provider(s) ("PAP's") for each episode is/are identified in the section defining the episode. In some cases, Medicaid may identify PAP's after an episode is complete using algorithms described in the episode definition.

2.a. Outpatient Hospital Services (continued)

PROPOSED

(4) The gain-sharing limit is set to avoid the risk of incentivizing care delivery at a cost that could compromise quality.

(5) The gain and risk sharing percentages aim to recognize required provider investment in practice change and will be set at a sustainable level for Medicaid.

(k) Outlier Patient Exclusions

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(3) Temporary stop-loss provisions may apply when necessary to ensure access to care.

(4) Providers that receive cost-based or PPS-based reimbursement are reimbursed as specified in the corresponding provider manual(s), but are subject to positive and negative supplemental payment incentives in order to achieve statewide improvement in quality and efficiency. For episodes including services furnished by providers who receive at exceptional reimbursement levels, reimbursements attributed to PAPs for the purpose of calculating performance are computed as if the provider did not receive exceptional reimbursement.

(5) Minimum case volume thresholds exclude from supplemental payment incentives those providers whose case-volume includes too few cases to generate a robust measure of performance. Medicaid will set a minimum case volume for each episode type. PAPs who do not meet the minimum case volume for an episode type will not be eligible for positive or negative supplemental payments for that episode type.

2.a. Outpatient Hospital Services (continued)

(n) Consideration of the aggregate cost and quality of care is not a retrospective review of the medical necessity of care rendered to any particular patient, nor is such consideration intended to supplant any retrospective review or other program integrity activity.

PROPOSED

2.b. Rural Health Clinic Services and other ambulatory services that are covered under the plan and furnished by a rural health clinic (Continued)

INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

(a) Definitions

(1) An "episode" refers to a defined collection of related Medicaid-covered health care services provided to a specific Medicaid beneficiary.
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PROPOSED

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(h) Principal Accountable Providers

The principal accountable provider(s) ("PAP's") for each episode is/are identified in the section defining the episode. In some cases, Medicaid may identify PAP's after an episode is complete using algorithms described in the episode definition.

2.b. Rural Health Clinic Services and other ambulatory services that are covered under the plan and furnished by a rural health clinic (Continued)

(i) Supplemental Payment Incentives

PROPOSED

For each PAP for each applicable episode type:

(1) Performance will be aggregated and assessed over a specified period of time ("performance period"). For each PAP, the average reimbursement across all relevant episodes completed during the performance period will be calculated, based on the set of services included in the episode definition published and made available to providers.

(2) Some episodes may be excluded and reimbursement for some episodes may be adjusted in this calculation, based on clinical or other factors, as described in definition of each episode.

(3) The average adjusted reimbursement of all episodes for the PAP during the performance period will be compared to thresholds established by Medicaid with advice from providers.

(4) If the average adjusted episode reimbursement is lower than the commendable threshold and the PAP has documented that the quality requirements established by Medicaid for each episode type have been met, Medicaid will make a positive supplemental payment to the PAP. This payment will be equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation and multiplied by a gain sharing percentage for the episode. Where necessary, a gain sharing limit will be established to avoid incentives for underutilization. PAPs with average adjusted episode reimbursement lower than the gain sharing limit will receive a supplemental payment calculated as though their average adjusted episode reimbursement were equal to the gain sharing limit.

(5) If the average episode reimbursement is higher than the acceptable threshold, the PAP will incur a negative supplemental payment. This payment to Medicaid will be equal to the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation and multiplied by a risk sharing percentage defined by Medicaid for the episode.

(j) Principles for determining "thresholds"

(1) The threshold process aims to incentivize high-quality clinical care delivered efficiently, and to consider several factors including the potential to improve patient access, the impact on provider economics, and the level and type of practice pattern changes required for performance improvement.

(2) The acceptable threshold is set such that underperforming the acceptable threshold reflects unacceptable performance, which could result from a large variation from typical performance without clinical justification (e.g., individual provider variation) or from system-wide variance from widely accepted clinical standards.

(3) The commendable threshold is set such that outperforming the commendable threshold represents quality care provided at a lower total reimbursement, which would result from care at meaningfully better than current average reimbursement in Arkansas, consistent with good medical outcomes. Medicaid may take into consideration what a clinically feasible target would be, as demonstrated by historical reimbursement variance in Arkansas.

2.b. Rural Health Clinic Services and other ambulatory services that are covered under the plan and furnished by a rural health clinic (Continued)

(4) The gain-sharing limit is set to avoid the risk of incentivizing care delivery at a cost that could compromise quality.

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2.b. Rural Health Clinic Services and other ambulatory services that are covered under the plan and furnished by a rural health clinic (Continued)

(n) Consideration of the aggregate cost and quality of care is not a retrospective review of the medical necessity of care rendered to any particular patient, nor is such consideration intended to supplant any retrospective review or other program integrity activity.

PROPOSED

2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4) (continued).

INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

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(h) Principal Accountable Providers

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2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4) (continued).

PROPOSED

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For each PAP for each applicable episode type:

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(j) Principles for determining "thresholds"

(1) The threshold process aims to incentivize high-quality clinical care delivered efficiently, and to consider several factors including the potential to improve patient access, the impact on provider economics, and the level and type of practice pattern changes required for performance improvement.

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2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4) (continued).

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2.c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4) (continued).

(n) Consideration of the aggregate cost and quality of care is not a retrospective review of the medical necessity of care rendered to any particular patient, nor is such consideration intended to supplant any retrospective review or other program integrity activity.

PROPOSED

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(16) RESERVED

PROPOSED

(17) Psychology Services

Reimbursement is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed. Some Medicaid maximums were established at 65% of the Blue Shield customary reflected in their publication dated 10/90. The other Medicaid maximums were established at 50% of the Rehabilitative Services for Persons with Mental Illness (RSPMI) fee schedule per procedure code. Refer to Attachment 4.19-B, Page 5a, Item 13.d.1.

Effective for claims with dates of service on or after July 1, 1992, the Title XIX maximum rates were decreased by 20%.

INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

(a) Definitions

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(b) Medicaid has established a payment improvement initiative ("payment improvement program") to incentivize improved care quality, efficiency, and economy. The program uses episode-based data to evaluate the quality, efficiency, and economy of care delivered in the course of the episode, and to apply payment incentives. **Please refer to the Episodes of Care Medicaid Manual for information about specific episodes.**

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4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(g) Medicaid establishes episode definitions, levels of supplemental incentive payments, and appropriate quality measures based on evidence-based practices. To identify evidence-based practices, Medicaid shall consider clinical information furnished by Arkansas providers of the care and services typically rendered during the episode of care, and may also consider input from one or more quality improvement organizations ("QIO's") or QIO-like entities, peer-reviewed medical literature, or any combination thereof.

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(i) Supplemental Payment Incentives

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(3) The average adjusted reimbursement of all episodes for the PAP during the performance period will be compared to thresholds established by Medicaid with advice from providers.

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(5) If the average episode reimbursement is higher than the acceptable threshold, the PAP will incur a negative supplemental payment. This payment to Medicaid will be equal to the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation and multiplied by a risk sharing percentage defined by Medicaid for the episode.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(j) Principles for determining "thresholds"

(1) The threshold process aims to incentivize high-quality clinical care delivered efficiently, and to consider several factors including the potential to improve patient access, the impact on provider economics, and the level and type of practice pattern changes required for performance improvement.

(2) The acceptable threshold is set such that underperforming the acceptable threshold reflects unacceptable performance, which could result from a large variation from typical performance without clinical justification (e.g., individual provider variation) or from system-wide variance from widely accepted clinical standards.

(3) The commendable threshold is set such that outperforming the commendable threshold represents quality care provided at a lower total reimbursement, which would result from care at meaningfully better than current average reimbursement in Arkansas, consistent with good medical outcomes. Medicaid may take into consideration what a clinically feasible target would be, as demonstrated by historical reimbursement variance in Arkansas.

(4) The gain-sharing limit is set to avoid the risk of incentivizing care delivery at a cost that could compromise quality.

(5) The gain and risk sharing percentages aim to recognize required provider investment in practice change and will be set at a sustainable level for Medicaid.

(k) Outlier Patient Exclusions

Calculation of average adjusted episode reimbursement for each PAP will exclude outlier patients who have extraordinarily high risk/severity so that one or a few cases do not meaningfully misrepresent a provider's performance across the provider's broader patient population.

(l) Provider-level adjustments

(1) Supplemental payment incentives for each PAP take into account provider-level adjustments, which may include stop-loss provisions, adjustments for cost-based facilities, adjustments or exclusions for providers with low case volume, or any combination thereof.

(2) Medicaid has modeled the potential impact of thresholds on individual providers given historical treatment patterns, and under a number of scenarios representing meaningful improvement towards a more consistent provision of evidence-based care, and have identified a number of providers of ADHD services that far exceed clinical expectations in the volume of services reimbursed for Medicaid beneficiaries, and for whom reimbursement for ADHD services represents a significant percentage of total Medicaid reimbursement. To help sustain these providers for a reasonable period of transition as they seek to achieve acceptable levels of reimbursement and a clinically appropriate volume of services for the treatment of ADHD, Medicaid will apply stop-loss protection across all episodes for one year such that the net negative supplemental payment payable in a period (i.e., the total of all negative supplemental payments in a period minus the total of all positive supplemental payments in the same period) is capped at 10% of Medicaid reimbursement in the period.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found (Continued)

(3) Temporary stop-loss provisions may apply when necessary to ensure access to care.

(4) Providers that receive cost-based or PPS-based reimbursement are reimbursed as specified in the corresponding provider manual(s), but are subject to positive and negative supplemental payment incentives in order to achieve statewide improvement in quality and efficiency. For episodes including services furnished by providers who receive at exceptional reimbursement levels, reimbursements attributed to PAPs for the purpose of calculating performance are computed as if the provider did not receive exceptional reimbursement.

(5) Minimum case volume thresholds exclude from supplemental payment incentives those providers whose case-volume includes too few cases to generate a robust measure of performance. Medicaid will set a minimum case volume for each episode type. PAPs who do not meet the minimum case volume for an episode type will not be eligible for positive or negative supplemental payments for that episode type.

(m) Quality

(1) For each episode type, there will be a set of quality metrics "to pass" and a set of quality metrics "to track." These quality metrics may be based on claims data or based on additional data specified by Medicaid which PAPs will be required to report.

(2) To quality for positive supplemental payments, PAPs must report all required data and meet specific thresholds for the quality metrics "to pass."

(3) Providers who do not report data or who do not meet minimum quality thresholds may still incur negative supplemental payments if their average adjusted episode reimbursement exceeds the acceptable threshold.

(n) Consideration of the aggregate cost and quality of care is not a retrospective review of the medical necessity of care rendered to any particular patient, nor is such consideration intended to supplant any retrospective review or other program integrity activity.

PROPOSED

PROPOSED

5. Physicians' Services (continued)

INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

(a) Definitions

(1) An "episode" refers to a defined collection of related Medicaid-covered health care services provided to a specific Medicaid beneficiary.
(2) An "episode type" is defined by a diagnosis, health care intervention, or condition during a specific timeframe (or performance period).
(3) "Thresholds" are the upper and lower reimbursement benchmarks for an episode of care.

(b) Medicaid has established a payment improvement initiative ("payment improvement program") to incentivize improved care quality, efficiency, and economy. The program uses episode-based data to evaluate the quality, efficiency, and economy of care delivered in the course of the episode, and to apply payment incentives. **Please refer to the Episodes of Care Medicaid Manual for information about specific episodes.**

(c) The payment improvement program is separate from, and does not alter, current methods for reimbursement.

(d) The payment improvement program promotes efficiency, economy, and quality of care by rewarding high-quality care and outcomes, encouraging clinical effectiveness, promoting early intervention and coordination to reduce complications and associated costs, and, when provider referrals are necessary, by encouraging referral to efficient and economic providers who furnish high-quality care.

(e) All medical assistance provided in the delivery of care for an episode may be included in the determination of a supplemental payment incentive under the payment improvement program.

(f) Payment incentives may be positive or negative. Incentive payments are calculated and made retrospectively after care has been completed and reimbursed in accordance with the published reimbursement methodology. Incentive payments are based on the aggregate of valid, paid claims across a provider's episodes and are not relatable to any individual provider claim for payment.

(g) Medicaid establishes episode definitions, levels of supplemental incentive payments, and appropriate quality measures based on evidence-based practices. To identify evidence-based practices, Medicaid shall consider clinical information furnished by Arkansas providers of the care and services typically rendered during the episode of care, and may also consider input from one or more quality improvement organizations ("QIO's") or QIO-like entities, peer-reviewed medical literature, or any combination thereof.

(h) Principal Accountable Providers

The principal accountable provider(s) ("PAP's") for each episode is/are identified in the section defining the episode. In some cases, Medicaid may identify PAP's after an episode is complete using algorithms described in the episode definition.

5. Physicians' Services (continued)

PROPOSED

(i) Supplemental Payment Incentives

For each PAP for each applicable episode type:

(1) Performance will be aggregated and assessed over a specified period of time ("performance period"). For each PAP, the average reimbursement across all relevant episodes completed during the performance period will be calculated, based on the set of services included in the episode definition published and made available to providers.

(2) Some episodes may be excluded and reimbursement for some episodes may be adjusted in this calculation, based on clinical or other factors, as described in definition of each episode.

(3) The average adjusted reimbursement of all episodes for the PAP during the performance period will be compared to thresholds established by Medicaid with advice from providers.

(4) If the average adjusted episode reimbursement is lower than the commendable threshold and the PAP has documented that the quality requirements established by Medicaid for each episode type have been met, Medicaid will make a positive supplemental payment to the PAP. This payment will be equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation and multiplied by a gain sharing percentage for the episode. Where necessary, a gain sharing limit will be established to avoid incentives for underutilization. PAPs with average adjusted episode reimbursement lower than the gain sharing limit will receive a supplemental payment calculated as though their average adjusted episode reimbursement were equal to the gain sharing limit.

(5) If the average episode reimbursement is higher than the acceptable threshold, the PAP will incur a negative supplemental payment. This payment to Medicaid will be equal to the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation and multiplied by a risk sharing percentage defined by Medicaid for the episode.

(j) Principles for determining "thresholds"

(1) The threshold process aims to incentivize high-quality clinical care delivered efficiently, and to consider several factors including the potential to improve patient access, the impact on provider economics, and the level and type of practice pattern changes required for performance improvement.

(2) The acceptable threshold is set such that underperforming the acceptable threshold reflects unacceptable performance, which could result from a large variation from typical performance without clinical justification (e.g., individual provider variation) or from system-wide variance from widely accepted clinical standards.

(3) The commendable threshold is set such that outperforming the commendable threshold represents quality care provided at a lower total reimbursement, which would result from care at meaningfully better than current average reimbursement in Arkansas, consistent with good medical outcomes. Medicaid may take into consideration what a clinically feasible target would be, as demonstrated by historical reimbursement variance in Arkansas.

5. Physicians' Services (continued)

(4) The gain-sharing limit is set to avoid the risk of incentivizing care delivery at a cost that could compromise quality.

(5) The gain and risk sharing percentages aim to recognize required provider investment in practice change and will be set at a sustainable level for Medicaid.

(k) Outlier Patient Exclusions

Calculation of average adjusted episode reimbursement for each PAP will exclude outlier patients who have extraordinarily high risk/severity so that one or a few cases do not meaningfully misrepresent a provider's performance across the provider's broader patient population.

(l) Provider-level adjustments

(1) Supplemental payment incentives for each PAP take into account provider-level adjustments, which may include stop-loss provisions, adjustments for cost-based facilities, adjustments or exclusions for providers with low case volume, or any combination thereof.

(2) Medicaid has modeled the potential impact of thresholds on individual providers given historical treatment patterns, and under a number of scenarios representing meaningful improvement towards a more consistent provision of evidence-based care, and have identified a number of providers of ADHD services that far exceed clinical expectations in the volume of services reimbursed for Medicaid beneficiaries, and for whom reimbursement for ADHD services represents a significant percentage of total Medicaid reimbursement. To help sustain these providers for a reasonable period of transition as they seek to achieve acceptable levels of reimbursement and a clinically appropriate volume of services for the treatment of ADHD, Medicaid will apply stop-loss protection across all episodes for one year such that the net negative supplemental payment payable in a period (i.e., the total of all negative supplemental payments in a period minus the total of all positive supplemental payments in the same period) is capped at 10% of Medicaid reimbursement in the period.

(3) Temporary stop-loss provisions may apply when necessary to ensure access to care.

(4) Providers that receive cost-based or PPS-based reimbursement are reimbursed as specified in the corresponding provider manual(s), but are subject to positive and negative supplemental payment incentives in order to achieve statewide improvement in quality and efficiency. For episodes including services furnished by providers who receive at exceptional reimbursement levels, reimbursements attributed to PAPs for the purpose of calculating performance are computed as if the provider did not receive exceptional reimbursement.

(5) Minimum case volume thresholds exclude from supplemental payment incentives those providers whose case-volume includes too few cases to generate a robust measure of performance. Medicaid will set a minimum case volume for each episode type. PAPs who do not meet the minimum case volume for an episode type will not be eligible for positive or negative supplemental payments for that episode type.

5. Physicians' Services (continued)

(m) Quality

(1) For each episode type, there will be a set of quality metrics "to pass" and a set of quality metrics "to track." These quality metrics may be based on claims data or based on additional data specified by Medicaid which PAPs will be required to report.

(2) To quality for positive supplemental payments, PAPs must report all required data and meet specific thresholds for the quality metrics "to pass."

(3) Providers who do not report data or who do not meet minimum quality thresholds may still incur negative supplemental payments if their average adjusted episode reimbursement exceeds the acceptable threshold.

(n) Consideration of the aggregate cost and quality of care is not a retrospective review of the medical necessity of care rendered to any particular patient, nor is such consideration intended to supplant any retrospective review or other program integrity activity.

PROPOSED

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

October 1, 2012

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

1. Rehabilitative Services for Persons with Mental Illness (RSPMI) (continued)

INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

(a) Definitions

(1) An "episode" refers to a defined collection of related Medicaid-covered health care services provided to a specific Medicaid beneficiary.
(2) An "episode type" is defined by a diagnosis, health care intervention, or condition during a specific timeframe (or performance period).
(3) "Thresholds" are the upper and lower reimbursement benchmarks for an episode of care.

(b) Medicaid has established a payment improvement initiative ("payment improvement program") to incentivize improved care quality, efficiency, and economy. The program uses episode-based data to evaluate the quality, efficiency, and economy of care delivered in the course of the episode, and to apply payment incentives. **Please refer to the Episodes of Care Medicaid Manual for information about specific episodes.**

(c) The payment improvement program is separate from, and does not alter, current methods for reimbursement.

(d) The payment improvement program promotes efficiency, economy, and quality of care by rewarding high-quality care and outcomes, encouraging clinical effectiveness, promoting early intervention and coordination to reduce complications and associated costs, and, when provider referrals are necessary, by encouraging referral to efficient and economic providers who furnish high-quality care.

(e) All medical assistance provided in the delivery of care for an episode may be included in the determination of a supplemental payment incentive under the payment improvement program.

(f) Payment incentives may be positive or negative. Incentive payments are calculated and made retrospectively after care has been completed and reimbursed in accordance with the published reimbursement methodology. Incentive payments are based on the aggregate of valid, paid claims across a provider's episodes and are not relatable to any individual provider claim for payment.

(g) Medicaid establishes episode definitions, levels of supplemental incentive payments, and appropriate quality measures based on evidence-based practices. To identify evidence-based practices, Medicaid shall consider clinical information furnished by Arkansas providers of the care and services typically rendered during the episode of care, and may also consider input from one or more quality improvement organizations ("QIO's") or QIO-like entities, peer-reviewed medical literature, or any combination thereof.

(h) Principal Accountable Providers

The principal accountable provider(s) ("PAP's") for each episode is/are identified in the section defining the episode. In some cases, Medicaid may identify PAP's after an episode is complete using algorithms described in the episode definition.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

(i) Supplemental Payment Incentives

For each PAP for each applicable episode type:

(1) Performance will be aggregated and assessed over a specified period of time ("performance period"). For each PAP, the average reimbursement across all relevant episodes completed during the performance period will be calculated, based on the set of services included in the episode definition published and made available to providers.

(2) Some episodes may be excluded and reimbursement for some episodes may be adjusted in this calculation, based on clinical or other factors, as described in definition of each episode.

(3) The average adjusted reimbursement of all episodes for the PAP during the performance period will be compared to thresholds established by Medicaid with advice from providers.

(4) If the average adjusted episode reimbursement is lower than the commendable threshold and the PAP has documented that the quality requirements established by Medicaid for each episode type have been met, Medicaid will make a positive supplemental payment to the PAP. This payment will be equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation and multiplied by a gain sharing percentage for the episode. Where necessary, a gain sharing limit will be established to avoid incentives for underutilization. PAPs with average adjusted episode reimbursement lower than the gain sharing limit will receive a supplemental payment calculated as though their average adjusted episode reimbursement were equal to the gain sharing limit.

(5) If the average episode reimbursement is higher than the acceptable threshold, the PAP will incur a negative supplemental payment. This payment to Medicaid will be equal to the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation and multiplied by a risk sharing percentage defined by Medicaid for the episode.

(j) Principles for determining "thresholds"

(1) The threshold process aims to incentivize high-quality clinical care delivered efficiently, and to consider several factors including the potential to improve patient access, the impact on provider economics, and the level and type of practice pattern changes required for performance improvement.

(2) The acceptable threshold is set such that underperforming the acceptable threshold reflects unacceptable performance, which could result from a large variation from typical performance without clinical justification (e.g., individual provider variation) or from system-wide variance from widely accepted clinical standards.

(3) The commendable threshold is set such that outperforming the commendable threshold represents quality care provided at a lower total reimbursement, which would result from care at meaningfully better than current average reimbursement in Arkansas, consistent with good medical outcomes. Medicaid may take into consideration what a clinically feasible target would be, as demonstrated by historical reimbursement variance in Arkansas.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

(4) The gain-sharing limit is set to avoid the risk of incentivizing care delivery at a cost that could compromise quality.

(5) The gain and risk sharing percentages aim to recognize required provider investment in practice change and will be set at a sustainable level for Medicaid.

(k) Outlier Patient Exclusions

Calculation of average adjusted episode reimbursement for each PAP will exclude outlier patients who have extraordinarily high risk/severity so that one or a few cases do not meaningfully misrepresent a provider's performance across the provider's broader patient population.

(l) Provider-level adjustments

(1) Supplemental payment incentives for each PAP take into account provider-level adjustments, which may include stop-loss provisions, adjustments for cost-based facilities, adjustments or exclusions for providers with low case volume, or any combination thereof.

(2) Medicaid has modeled the potential impact of thresholds on individual providers given historical treatment patterns, and under a number of scenarios representing meaningful improvement towards a more consistent provision of evidence-based care, and have identified a number of providers of ADHD services that far exceed clinical expectations in the volume of services reimbursed for Medicaid beneficiaries, and for whom reimbursement for ADHD services represents a significant percentage of total Medicaid reimbursement. To help sustain these providers for a reasonable period of transition as they seek to achieve acceptable levels of reimbursement and a clinically appropriate volume of services for the treatment of ADHD, Medicaid will apply stop-loss protection across all episodes for one year such that the net negative supplemental payment payable in a period (i.e., the total of all negative supplemental payments in a period minus the total of all positive supplemental payments in the same period) is capped at 10% of Medicaid reimbursement in the period.

(3) Temporary stop-loss provisions may apply when necessary to ensure access to care.

(4) Providers that receive cost-based or PPS-based reimbursement are reimbursed as specified in the corresponding provider manual(s), but are subject to positive and negative supplemental payment incentives in order to achieve statewide improvement in quality and efficiency. For episodes including services furnished by providers who receive at exceptional reimbursement levels, reimbursements attributed to PAPs for the purpose of calculating performance are computed as if the provider did not receive exceptional reimbursement.

(5) Minimum case volume thresholds exclude from supplemental payment incentives those providers whose case-volume includes too few cases to generate a robust measure of performance. Medicaid will set a minimum case volume for each episode type. PAPs who do not meet the minimum case volume for an episode type will not be eligible for positive or negative supplemental payments for that episode type.

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

(m) Quality

(1) For each episode type, there will be a set of quality metrics "to pass" and a set of quality metrics "to track." These quality metrics may be based on claims data or based on additional data specified by Medicaid which PAPs will be required to report.

(2) To quality for positive supplemental payments, PAPs must report all required data and meet specific thresholds for the quality metrics "to pass."

(3) Providers who do not report data or who do not meet minimum quality thresholds may still incur negative supplemental payments if their average adjusted episode reimbursement exceeds the acceptable threshold.

(n) Consideration of the aggregate cost and quality of care is not a retrospective review of the medical necessity of care rendered to any particular patient, nor is such consideration intended to supplant any retrospective review or other program integrity activity.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (Continued)

e. Emergency Hospital Services (continued)

INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

(a) Definitions

(1) An "episode" refers to a defined collection of related Medicaid-covered health care services provided to a specific Medicaid beneficiary.
(2) An "episode type" is defined by a diagnosis, health care intervention, or condition during a specific timeframe (or performance period).
(3) "Thresholds" are the upper and lower reimbursement benchmarks for an episode of care.

(b) Medicaid has established a payment improvement initiative ("payment improvement program") to incentivize improved care quality, efficiency, and economy. The program uses episode-based data to evaluate the quality, efficiency, and economy of care delivered in the course of the episode, and to apply payment incentives. **Please refer to the Episodes of Care Medicaid Manual for information about specific episodes.**

(c) The payment improvement program is separate from, and does not alter, current methods for reimbursement.

(d) The payment improvement program promotes efficiency, economy, and quality of care by rewarding high-quality care and outcomes, encouraging clinical effectiveness, promoting early intervention and coordination to reduce complications and associated costs, and, when provider referrals are necessary, by encouraging referral to efficient and economic providers who furnish high-quality care.

(e) All medical assistance provided in the delivery of care for an episode may be included in the determination of a supplemental payment incentive under the payment improvement program.

(f) Payment incentives may be positive or negative. Incentive payments are calculated and made retrospectively after care has been completed and reimbursed in accordance with the published reimbursement methodology. Incentive payments are based on the aggregate of valid, paid claims across a provider's episodes and are not relatable to any individual provider claim for payment.

(g) Medicaid establishes episode definitions, levels of supplemental incentive payments, and appropriate quality measures based on evidence-based practices. To identify evidence-based practices, Medicaid shall consider clinical information furnished by Arkansas providers of the care and services typically rendered during the episode of care, and may also consider input from one or more quality improvement organizations ("QIO's") or QIO-like entities, peer-reviewed medical literature, or any combination thereof.

(h) Principal Accountable Providers

The principal accountable provider(s) ("PAP's") for each episode is/are identified in the section defining the episode. In some cases, Medicaid may identify PAP's after an episode is complete using algorithms described in the episode definition.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (Continued)

e. Emergency Hospital Services (continued)

(i) Supplemental Payment Incentives

For each PAP for each applicable episode type:

(1) Performance will be aggregated and assessed over a specified period of time ("performance period"). For each PAP, the average reimbursement across all relevant episodes completed during the performance period will be calculated, based on the set of services included in the episode definition published and made available to providers.

(2) Some episodes may be excluded and reimbursement for some episodes may be adjusted in this calculation, based on clinical or other factors, as described in definition of each episode.

(3) The average adjusted reimbursement of all episodes for the PAP during the performance period will be compared to thresholds established by Medicaid with advice from providers.

(4) If the average adjusted episode reimbursement is lower than the commendable threshold and the PAP has documented that the quality requirements established by Medicaid for each episode type have been met, Medicaid will make a positive supplemental payment to the PAP. This payment will be equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation and multiplied by a gain sharing percentage for the episode. Where necessary, a gain sharing limit will be established to avoid incentives for underutilization. PAPs with average adjusted episode reimbursement lower than the gain sharing limit will receive a supplemental payment calculated as though their average adjusted episode reimbursement were equal to the gain sharing limit.

(5) If the average episode reimbursement is higher than the acceptable threshold, the PAP will incur a negative supplemental payment. This payment to Medicaid will be equal to the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation and multiplied by a risk sharing percentage defined by Medicaid for the episode.

(j) Principles for determining "thresholds"

(1) The threshold process aims to incentivize high-quality clinical care delivered efficiently, and to consider several factors including the potential to improve patient access, the impact on provider economics, and the level and type of practice pattern changes required for performance improvement.

(2) The acceptable threshold is set such that underperforming the acceptable threshold reflects unacceptable performance, which could result from a large variation from typical performance without clinical justification (e.g., individual provider variation) or from system-wide variance from widely accepted clinical standards.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (Continued)

PROPOSED

e. Emergency Hospital Services (continued)

(3) The commendable threshold is set such that outperforming the commendable threshold represents quality care provided at a lower total reimbursement, which would result from care at meaningfully better than current average reimbursement in Arkansas, consistent with good medical outcomes. Medicaid may take into consideration what a clinically feasible target would be, as demonstrated by historical reimbursement variance in Arkansas.

(4) The gain-sharing limit is set to avoid the risk of incentivizing care delivery at a cost that could compromise quality.

(5) The gain and risk sharing percentages aim to recognize required provider investment in practice change and will be set at a sustainable level for Medicaid.

(k) Outlier Patient Exclusions

Calculation of average adjusted episode reimbursement for each PAP will exclude outlier patients who have extraordinarily high risk/severity so that one or a few cases do not meaningfully misrepresent a provider's performance across the provider's broader patient population.

(l) Provider-level adjustments

(1) Supplemental payment incentives for each PAP take into account provider-level adjustments, which may include stop-loss provisions, adjustments for cost-based facilities, adjustments or exclusions for providers with low case volume, or any combination thereof.

(2) Medicaid has modeled the potential impact of thresholds on individual providers given historical treatment patterns, and under a number of scenarios representing meaningful improvement towards a more consistent provision of evidence-based care, and have identified a number of providers of ADHD services that far exceed clinical expectations in the volume of services reimbursed for Medicaid beneficiaries, and for whom reimbursement for ADHD services represents a significant percentage of total Medicaid reimbursement. To help sustain these providers for a reasonable period of transition as they seek to achieve acceptable levels of reimbursement and a clinically appropriate volume of services for the treatment of ADHD, Medicaid will apply stop-loss protection across all episodes for one year such that the net negative supplemental payment payable in a period (i.e., the total of all negative supplemental payments in a period minus the total of all positive supplemental payments in the same period) is capped at 10% of Medicaid reimbursement in the period.

(3) Temporary stop-loss provisions may apply when necessary to ensure access to care.

(4) Providers that receive cost-based or PPS-based reimbursement are reimbursed as specified in the corresponding provider manual(s), but are subject to positive and negative supplemental payment incentives in order to achieve statewide improvement in quality and efficiency. For episodes including services furnished by providers who receive at exceptional reimbursement levels, reimbursements attributed to PAPs for the purpose of calculating performance are computed as if the provider did not receive exceptional reimbursement.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary. (Continued)

e. Emergency Hospital Services (continued)

(5) Minimum case volume thresholds exclude from supplemental payment incentives those providers whose case-volume includes too few cases to generate a robust measure of performance. Medicaid will set a minimum case volume for each episode type. PAPs who do not meet the minimum case volume for an episode type will not be eligible for positive or negative supplemental payments for that episode type.

(m) Quality

(1) For each episode type, there will be a set of quality metrics "to pass" and a set of quality metrics "to track." These quality metrics may be based on claims data or based on additional data specified by Medicaid which PAPs will be required to report.

(2) To quality for positive supplemental payments, PAPs must report all required data and meet specific thresholds for the quality metrics "to pass."

(3) Providers who do not report data or who do not meet minimum quality thresholds may still incur negative supplemental payments if their average adjusted episode reimbursement exceeds the acceptable threshold.

(n) Consideration of the aggregate cost and quality of care is not a retrospective review of the medical necessity of care rendered to any particular patient, nor is such consideration intended to supplant any retrospective review or other program integrity activity.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary (continued).

f. Critical Access Hospitals (CAH) (continued)

INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

(a) Definitions

(1) An "episode" refers to a defined collection of related Medicaid-covered health care services provided to a specific Medicaid beneficiary.
(2) An "episode type" is defined by a diagnosis, health care intervention, or condition during a specific timeframe (or performance period).
(3) "Thresholds" are the upper and lower reimbursement benchmarks for an episode of care.

(b) Medicaid has established a payment improvement initiative ("payment improvement program") to incentivize improved care quality, efficiency, and economy. The program uses episode-based data to evaluate the quality, efficiency, and economy of care delivered in the course of the episode, and to apply payment incentives. **Please refer to the Episodes of Care Medicaid Manual for information about specific episodes.**

(c) The payment improvement program is separate from, and does not alter, current methods for reimbursement.

(d) The payment improvement program promotes efficiency, economy, and quality of care by rewarding high-quality care and outcomes, encouraging clinical effectiveness, promoting early intervention and coordination to reduce complications and associated costs, and, when provider referrals are necessary, by encouraging referral to efficient and economic providers who furnish high-quality care.

(e) All medical assistance provided in the delivery of care for an episode may be included in the determination of a supplemental payment incentive under the payment improvement program.

(f) Payment incentives may be positive or negative. Incentive payments are calculated and made retrospectively after care has been completed and reimbursed in accordance with the published reimbursement methodology. Incentive payments are based on the aggregate of valid, paid claims across a provider's episodes and are not relatable to any individual provider claim for payment.

(g) Medicaid establishes episode definitions, levels of supplemental incentive payments, and appropriate quality measures based on evidence-based practices. To identify evidence-based practices, Medicaid shall consider clinical information furnished by Arkansas providers of the care and services typically rendered during the episode of care, and may also consider input from one or more quality improvement organizations ("QIO's") or QIO-like entities, peer-reviewed medical literature, or any combination thereof.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary (continued).

PROPOSED

f. Critical Access Hospitals (CAH) (continued)

(h) Principal Accountable Providers

The principal accountable provider(s) ("PAP's") for each episode is/are identified in the section defining the episode. In some cases, Medicaid may identify PAP's after an episode is complete using algorithms described in the episode definition.

(i) Supplemental Payment Incentives

For each PAP for each applicable episode type:

(1) Performance will be aggregated and assessed over a specified period of time ("performance period"). For each PAP, the average reimbursement across all relevant episodes completed during the performance period will be calculated, based on the set of services included in the episode definition published and made available to providers.

(2) Some episodes may be excluded and reimbursement for some episodes may be adjusted in this calculation, based on clinical or other factors, as described in definition of each episode.

(3) The average adjusted reimbursement of all episodes for the PAP during the performance period will be compared to thresholds established by Medicaid with advice from providers.

(4) If the average adjusted episode reimbursement is lower than the commendable threshold and the PAP has documented that the quality requirements established by Medicaid for each episode type have been met, Medicaid will make a positive supplemental payment to the PAP. This payment will be equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation and multiplied by a gain sharing percentage for the episode. Where necessary, a gain sharing limit will be established to avoid incentives for underutilization. PAPs with average adjusted episode reimbursement lower than the gain sharing limit will receive a supplemental payment calculated as though their average adjusted episode reimbursement were equal to the gain sharing limit.

(5) If the average episode reimbursement is higher than the acceptable threshold, the PAP will incur a negative supplemental payment. This payment to Medicaid will be equal to the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation and multiplied by a risk sharing percentage defined by Medicaid for the episode.

(j) Principles for determining "thresholds"

(1) The threshold process aims to incentivize high-quality clinical care delivered efficiently, and to consider several factors including the potential to improve patient access, the impact on provider economics, and the level and type of practice pattern changes required for performance improvement.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary (continued).

f. Critical Access Hospitals (CAH) (continued)

PROPOSED

(2) The acceptable threshold is set such that underperforming the acceptable threshold reflects unacceptable performance, which could result from a large variation from typical performance without clinical justification (e.g., individual provider variation) or from system-wide variance from widely accepted clinical standards.

(3) The commendable threshold is set such that outperforming the commendable threshold represents quality care provided at a lower total reimbursement, which would result from care at meaningfully better than current average reimbursement in Arkansas, consistent with good medical outcomes. Medicaid may take into consideration what a clinically feasible target would be, as demonstrated by historical reimbursement variance in Arkansas.

(4) The gain-sharing limit is set to avoid the risk of incentivizing care delivery at a cost that could compromise quality.

(5) The gain and risk sharing percentages aim to recognize required provider investment in practice change and will be set at a sustainable level for Medicaid.

(k) Outlier Patient Exclusions

Calculation of average adjusted episode reimbursement for each PAP will exclude outlier patients who have extraordinarily high risk/severity so that one or a few cases do not meaningfully misrepresent a provider's performance across the provider's broader patient population.

(l) Provider-level adjustments

(1) Supplemental payment incentives for each PAP take into account provider-level adjustments, which may include stop-loss provisions, adjustments for cost-based facilities, adjustments or exclusions for providers with low case volume, or any combination thereof.

(2) Medicaid has modeled the potential impact of thresholds on individual providers given historical treatment patterns, and under a number of scenarios representing meaningful improvement towards a more consistent provision of evidence-based care, and have identified a number of providers of ADHD services that far exceed clinical expectations in the volume of services reimbursed for Medicaid beneficiaries, and for whom reimbursement for ADHD services represents a significant percentage of total Medicaid reimbursement. To help sustain these providers for a reasonable period of transition as they seek to achieve acceptable levels of reimbursement and a clinically appropriate volume of services for the treatment of ADHD, Medicaid will apply stop-loss protection across all episodes for one year such that the net negative supplemental payment payable in a period (i.e., the total of all negative supplemental payments in a period minus the total of all positive supplemental payments in the same period) is capped at 10% of Medicaid reimbursement in the period.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary (continued).

f. Critical Access Hospitals (CAH) (continued)

(3) Temporary stop-loss provisions may apply when necessary to ensure access to care.

(4) Providers that receive cost-based or PPS-based reimbursement are reimbursed as specified in the corresponding provider manual(s), but are subject to positive and negative supplemental payment incentives in order to achieve statewide improvement in quality and efficiency. For episodes including services furnished by providers who receive at exceptional reimbursement levels, reimbursements attributed to PAPs for the purpose of calculating performance are computed as if the provider did not receive exceptional reimbursement.

(5) Minimum case volume thresholds exclude from supplemental payment incentives those providers whose case-volume includes too few cases to generate a robust measure of performance. Medicaid will set a minimum case volume for each episode type. PAPs who do not meet the minimum case volume for an episode type will not be eligible for positive or negative supplemental payments for that episode type.

(m) Quality

(1) For each episode type, there will be a set of quality metrics "to pass" and a set of quality metrics "to track." These quality metrics may be based on claims data or based on additional data specified by Medicaid which PAPs will be required to report.

(2) To quality for positive supplemental payments, PAPs must report all required data and meet specific thresholds for the quality metrics "to pass."

(3) Providers who do not report data or who do not meet minimum quality thresholds may still incur negative supplemental payments if their average adjusted episode reimbursement exceeds the acceptable threshold.

(n) Consideration of the aggregate cost and quality of care is not a retrospective review of the medical necessity of care rendered to any particular patient, nor is such consideration intended to supplant any retrospective review or other program integrity activity.

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Reimbursement is based on the lower of the amount billed or the Title XIX maximum allowable.

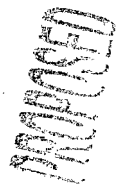
The Title XIX maximum is 80% of the physician fee schedule except EPSDT procedure codes. Medicaid maximum allowables are the same for all EPSDT providers. Immunizations and Rhogam RhoD Immune Globulin are reimbursed at the same rate as the physician rate since the cost and administration of the drug does not vary between the advanced practice nurse and physician.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of services provided by Advanced Practice Nurse. The agency's fee schedule rate was set as of April 1, 2004 and is effective for services provided on or after that date. All rates are published on the agency's website@ www.medicaid.state.ar.us.

INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

(a) Definitions

(1) An "episode" refers to a defined collection of related Medicaid-covered health care services provided to a specific Medicaid beneficiary.
(2) An "episode type" is defined by a diagnosis, health care intervention, or condition during a specific timeframe (or performance period).
(3) "Thresholds" are the upper and lower reimbursement benchmarks for an episode of care.



(b) Medicaid has established a payment improvement initiative ("payment improvement program") to incentivize improved care quality, efficiency, and economy. The program uses episode-based data to evaluate the quality, efficiency, and economy of care delivered in the course of the episode, and to apply payment incentives. **Please refer to the Episodes of Care Medicaid Manual for information about specific episodes.**

(c) The payment improvement program is separate from, and does not alter, current methods for reimbursement.

(d) The payment improvement program promotes efficiency, economy, and quality of care by rewarding high-quality care and outcomes, encouraging clinical effectiveness, promoting early intervention and coordination to reduce complications and associated costs, and, when provider referrals are necessary, by encouraging referral to efficient and economic providers who furnish high-quality care.

(e) All medical assistance provided in the delivery of care for an episode may be included in the determination of a supplemental payment incentive under the payment improvement program.

(f) Payment incentives may be positive or negative. Incentive payments are calculated and made retrospectively after care has been completed and reimbursed in accordance with the published reimbursement methodology. Incentive payments are based on the aggregate of valid, paid claims across a provider's episodes and are not relatable to any individual provider claim for payment.

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(g) Medicaid establishes episode definitions, levels of supplemental incentive payments, and appropriate quality measures based on evidence-based practices. To identify evidence-based practices, Medicaid shall consider clinical information furnished by Arkansas providers of the care and services typically rendered during the episode of care, and may also consider input from one or more quality improvement organizations ("QIO's") or QIO-like entities, peer-reviewed medical literature, or any combination thereof.

(h) Principal Accountable Providers

The principal accountable provider(s) ("PAP's") for each episode is/are identified in the section defining the episode. In some cases, Medicaid may identify PAP's after an episode is complete using algorithms described in the episode definition.

(i) Supplemental Payment Incentives

For each PAP for each applicable episode type:

(1) Performance will be aggregated and assessed over a specified period of time ("performance period"). For each PAP, the average reimbursement across all relevant episodes completed during the performance period will be calculated, based on the set of services included in the episode definition published and made available to providers.

(2) Some episodes may be excluded and reimbursement for some episodes may be adjusted in this calculation, based on clinical or other factors, as described in definition of each episode.

(3) The average adjusted reimbursement of all episodes for the PAP during the performance period will be compared to thresholds established by Medicaid with advice from providers.

(4) If the average adjusted episode reimbursement is lower than the commendable threshold and the PAP has documented that the quality requirements established by Medicaid for each episode type have been met, Medicaid will make a positive supplemental payment to the PAP. This payment will be equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation and multiplied by a gain sharing percentage for the episode. Where necessary, a gain sharing limit will be established to avoid incentives for underutilization. PAPs with average adjusted episode reimbursement lower than the gain sharing limit will receive a supplemental payment calculated as though their average adjusted episode reimbursement were equal to the gain sharing limit.

(5) If the average episode reimbursement is higher than the acceptable threshold, the PAP will incur a negative supplemental payment. This payment to Medicaid will be equal to the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation and multiplied by a risk sharing percentage defined by Medicaid for the episode.

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(j) Principles for determining "thresholds"

(1) The threshold process aims to incentivize high-quality clinical care delivered efficiently, and to consider several factors including the potential to improve patient access, the impact on provider economics, and the level and type of practice pattern changes required for performance improvement.

(2) The acceptable threshold is set such that underperforming the acceptable threshold reflects unacceptable performance, which could result from a large variation from typical performance without clinical justification (e.g., individual provider variation) or from system-wide variance from widely accepted clinical standards.

(3) The commendable threshold is set such that outperforming the commendable threshold represents quality care provided at a lower total reimbursement, which would result from care at meaningfully better than current average reimbursement in Arkansas, consistent with good medical outcomes. Medicaid may take into consideration what a clinically feasible target would be, as demonstrated by historical reimbursement variance in Arkansas.

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(2) Medicaid has modeled the potential impact of thresholds on individual providers given historical treatment patterns, and under a number of scenarios representing meaningful improvement towards a more consistent provision of evidence-based care, and have identified a number of providers of ADHD services that far exceed clinical expectations in the volume of services reimbursed for Medicaid beneficiaries, and for whom reimbursement for ADHD services represents a significant percentage of total Medicaid reimbursement. To help sustain these providers for a reasonable period of transition as they seek to achieve acceptable levels of reimbursement and a clinically appropriate volume of services for the treatment of ADHD, Medicaid will apply stop-loss protection across all episodes for one year such that the net negative supplemental payment payable in a period (i.e., the total of all negative supplemental payments in a period minus the total of all positive supplemental payments in the same period) is capped at 10% of Medicaid reimbursement in the period.

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(3) Temporary stop-loss provisions may apply when necessary to ensure access to care.

(4) Providers that receive cost-based or PPS-based reimbursement are reimbursed as specified in the corresponding provider manual(s), but are subject to positive and negative supplemental payment incentives in order to achieve statewide improvement in quality and efficiency. For episodes including services furnished by providers who receive at exceptional reimbursement levels, reimbursements attributed to PAPs for the purpose of calculating performance are computed as if the provider did not receive exceptional reimbursement.

(5) Minimum case volume thresholds exclude from supplemental payment incentives those providers whose case-volume includes too few cases to generate a robust measure of performance. Medicaid will set a minimum case volume for each episode type. PAPs who do not meet the minimum case volume for an episode type will not be eligible for positive or negative supplemental payments for that episode type.

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(1) For each episode type, there will be a set of quality metrics "to pass" and a set of quality metrics "to track." These quality metrics may be based on claims data or based on additional data specified by Medicaid which PAPs will be required to report.

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