Healthcare Quality and Payment Policy Advisory Committee (HQPPAC)
Written Advisory Statement
May 6, 2016

1. General Recommendation Across all Proposed Episodes of Care
Arkansas Medicaid Provider Manual Section II 222.600 Thresholds for Incentive Payments – Committee discussion centered on impact of future Medicaid reimbursement rate changes on set thresholds. Is it possible for DMS to build something into policy that if provider reimbursement rates change, DMS would adjust thresholds accordingly? This issue is applicable across all four new episodes presented in this meeting.

DHS Response: The current Arkansas Medicaid Provider Manual Section I 181.000 J. Principles for Determining “Thresholds” contains the following statements: Item 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 changes required for performance improvement.’ Item 3: ‘Medicaid may take into consideration what a clinically-feasible target would be, as demonstrated by historical reimbursement variance in Arkansas.’ DMS will delete the referenced statement in Item 3 and add it to Item 1. Additionally, DMS will add the following statement to Item 1: ‘DMS will continuously review episodes of care to monitor the impact of provider economics/resource costs on thresholds and take action as deemed appropriate. Current tools such as quarterly episode milestone reports and EOC report card are monitored after each payment release.

2. Hysterectomy Episode of Care Proposed Draft Rules
Arkansas Medicaid Provider Manual Section II 222.300 Exclusions – DMS brought to the attention of the committee that an item was missing from the exclusions list. As recommended by the committee at the February 12, 2016 meeting, the following item should be added:
D. Beneficiaries with extraordinarily high- or low-cost outliers
Arkansas Medicaid Provider Manual Section II 222.500 Quality measures “to track” – DMS brought to the attention of the committee that due to the change from ICD-9 to ICD-10 coding, this metric must be reworded as follows:
1. Percent of episodes performed using an open method or were converted to open from laparoscopic method.

DHS Response: DMS will make the stated changes above regarding Section II 222.300 Exclusions and 222.500 Quality Measures “to track”.

3. Appendectomy Episode of Care Proposed Draft Rules
Arkansas Medicaid Provider Manual Section II 224.500 A. Quality measures “to track” – Committee discussion resulted in a recommendation to add a 3rd, 4th, and possibly a 5th metric to track rate of CT Scans, Ultra Sounds (US), and abdominal x-rays prior to procedure to identify appropriate abdominal imaging.

DHS Response: DMS accepts the recommendation to expand quality metrics ‘to track’ to include the separation of CT Scans and Ultra Sounds. The addition of a 5th quality metric ‘to track’ for abdominal x-rays is not supported by data.
4. **Uncomplicated Pediatric Pneumonia Episode of Care Proposed Draft Rules**

   Arkansas Medicaid Provider Manual Section II 225.100 B. Episode Trigger – Committee discussion regarding clarification of diagnoses that actually trigger an episode. Their concern is that the word ‘primary’ in front of diagnosis indicates a Dx1 diagnosis of pneumonia and it excludes all other types of pneumonia. For example, according to the way this is written a primary diagnosis of RSV would not trigger an episode, but a diagnosis of pneumonia caused by RSV would be a trigger. Should we consider broadening the definition in this episode to be inclusive of secondary diagnoses (Dx2-9) as well as Dx1?

   Arkansas Medicaid Provider Manual Section II 225.300 - If a diagnosis of RSV is not a trigger, is it included in the episode specific exclusions?

   **DHS Response:** The design of this EOC follows the acute facility archetype which captures only those diagnoses located in the primary (Dx1) position on the claim as an episode trigger. RSV alone will not trigger an episode, but pneumonia due to RSV would trigger an episode. Triggers will not be expanded to include diagnoses listed in secondary positions (Dx2-9). RSV alone is not an episode specific exclusion. Pneumonia with RSV is a statistically significant risk factor and as a risk factor does impact cost.

   Arkansas Medicaid Provider Manual Section II 225.300 - The committee recommended the removal of Parkinson’s disease and MS from the episode specific exclusions list. They questioned the need for their inclusion in a pediatric episode.

   **DHS Response:** DHS accepts the recommendation of the committee to remove Parkinson’s disease from the list of episode specific exclusions. Literature review indicates that Multiple Sclerosis (MS) is being diagnosed earlier and many cases are diagnosed before age 18. MS will remain an episode specific exclusion.

   Arkansas Medicaid Provider Manual Section II 225.500 – The committee recommended we switch the two quality measures – move metric regarding inappropriate use of antibiotics to tracking; move the rate of chest imaging to passing for gain share with a recommended pass rate of 75%. Is it possible to identify CTs? X-rays? This would require data identification from both IP and OP claims.

   **DHS Response:** DHS accepts the recommendation of the committee to move the quality metric regarding inappropriate use of antibiotics from a metric ‘to pass’ to a metric ‘to track’ and move the rate of chest imaging from a metric ‘to track’ to a metric ‘to pass’ for gain share with a recommended pass rate of 75%. Projections show that the majority of PAPs will pass this quality metric threshold.

5. **Urinary Tract Infection (UTI) Episode of Care Draft Rules**

   Arkansas Medicaid Provider Manual Section II 226.100 B. Episode Trigger – This is an outpatient only episode. What specific claim type(s) identify the trigger? M? J? How does provider type(s) impact trigger – i.e. contract ER physician vs. physician on staff at the facility? What is the impact on the trigger if the visit is deemed non-emergent and the facility does not file a claim but the attending physician does? What is the impact if the PCP is contacted to receive a referral and the referral is not granted? Concern expressed about the facility being the PAP if the
episode is not triggered by a facility claim. Question posed regarding medical screens during triage. Is there a diagnosis code attached to the claim?

**DHS Response:** *UTI episodes are triggered only by claim type ‘M’ (outpatient facility). The designated PAP for this episode is the facility; therefore, there is no impact regarding episodes on a PCP in private practice. The PAP will remain the facility. Hospitals do not receive reimbursement if an ED visit is deemed non-emergent.*

Arkansas Medicaid Provider Manual Section II 226.300 Exclusions - Is pregnancy missing from the global exclusion list in Section II 200.300? If not, should we list it in each episode as an episode specific exclusion? Diapers, catheters, history of prior urologist care needs to be addressed as exclusions in this episode.

**DHS Response:** *While pregnancy is included as a global exclusion in episode code sets, it was mistakenly left off the global exclusion list in Arkansas Medicaid Provider Manual Section II 200.300 (Exclusions). It will be added to this list of global exclusions.*

*Beneficiaries aged 4 and over with prescriptions filled for diapers are currently included in the list of episode specific exclusions of comorbidities within 365 days prior to the episode for the UTI episode of care. The following will be added to the list of episode specific exclusions of comorbidities within 365 days prior to the episode: beneficiaries using catheters. Data analysis regarding history of prior urologist care resulted in zero instances found in paid claims. Data analysis regarding repeat UTI visits did not surface as a statistically significant risk factor impacting cost.*

Arkansas Medicaid Provider Manual Section II 226.400 Adjustments - Is age of beneficiary a risk factor for higher cost?

**DHS Response:** *Data analysis did not show beneficiary age as a statistically significant risk factor.*

Arkansas Medicaid Provider Manual Section II 226.500 Quality Measures - Should age be a factor in determining quality metric regarding urine cultures? Should we add a quality measure ‘to track’ the rate of abdominal CT Scans? How is Ceftriaxone treated in the list of inappropriate antibiotics?

**DHS Response:** *The consideration of age as a factor impacting the urine culture quality metric is not supported by data. DHS accepts the recommendation to add a quality metric ‘to track’ the rate of abdominal CT Scans. Ceftriaxone is a 3rd generation cephalosporin and as such is included in the list of inappropriate antibiotics.*