September 19, 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-1-12 and State Plan Amendment #2012-014

If you have any questions or comments, please address them to Division of Medical Services, Program Planning and Development, P. O. Box 1437, Mail Slot S-295, Little Rock, AR  72203-1437.

Sincerely,

[Signature]

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 Robbie Nix
ADDRESS P.O Box 1437, Slot S295, Little Rock, AR 72203
PHONE NO. 682-8577 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-1-12 and State Plan Amendment #2012-014

2. What is the subject of the proposed rule?
   To add Congestive Heart Failure (CHF) episodes and Total Joint Replacement episodes to both the Episodes of Care Medicaid manual and the Arkansas State Plan.

3. Is this rule required to comply with a federal statute, rule, or regulation? Yes ____ No ____
   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 ____
   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 ___ No __ X__ 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 __ X__ No ____ 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 add Congestive Heart Failure (CHF) episodes and Total Joint Replacement episodes to both the Episodes of Care Medicaid manual and the Arkansas State Plan. 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 for Congestive Heart Failure (CHF) episodes and Total Joint Replacement episodes.

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: _______ TBA
   Time: _______ TBA
   Place: _______ TBA

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

    October 21, 2012

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

    January 1, 2013

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 Tom Show
TELEPHONE NO. 682-2483 FAX NO. 682-3889 EMAIL: tom.show@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-1-12 and State Plan Amendment #2012-014

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.

<table>
<thead>
<tr>
<th>Current Fiscal Year</th>
<th>Next Fiscal Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Revenue</td>
<td>General Revenue</td>
</tr>
<tr>
<td>Federal Funds</td>
<td>Federal Funds</td>
</tr>
<tr>
<td>Cash Funds</td>
<td>Cash Funds</td>
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<tr>
<td>Special Revenue</td>
<td>Special Revenue</td>
</tr>
<tr>
<td>Other (Identify)</td>
<td>Other (Identify)</td>
</tr>
<tr>
<td>Total</td>
<td>Total</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Current Fiscal Year</th>
<th>Next Fiscal Year</th>
</tr>
</thead>
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</table>

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)

<table>
<thead>
<tr>
<th>Current Fiscal Year (2013)</th>
<th>Next Fiscal Year (2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 15,589 State</td>
<td>$ 19,190 State</td>
</tr>
<tr>
<td>$ 36,669 Federal</td>
<td>$ 45,444 Federal</td>
</tr>
<tr>
<td>$ 52,258 Total Savings</td>
<td>$64,634 Total Savings</td>
</tr>
</tbody>
</table>
ECONOMIC IMPACT STATEMENT
(As Required under Arkansas Code § 25-15-301)

Department: Arkansas Department of Human Services
Division: Medical Services
Person Completing this Statement: Tom Show
Telephone Number: 501-682-2483 Fax Number: 501-682-3889
EMAIL: Tom.Show@Arkansas.gov

Short Title of this Rule: EPISODE-1-12 and State Plan Amendment #2012-014

(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.

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 $64,634 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-1-12 and State Plan Amendment #2012-014

Effective January 1, 2013 Arkansas Medicaid proposes to add Congestive Heart Failure (CHF) episodes and Total Joint Replacement episodes to the Episodes of Care Medicaid manual and Arkansas State Plan 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.
TO: Arkansas Medicaid Health Care Providers – All Providers

DATE: January 1, 2013

SUBJECT: Provider Manual Update Transmittal EPISODE-1-12

**Explanation of Updates**

Sections 213.000, 213.100, 213.200, 213.300, 213.400, 213.500, 213.600, and 213.700 are new sections with information pertaining to the Congestive Heart Failure (CHF) episode of care.

Sections 214.000, 214.100, 214.200, 214.300, 214.400, 214.500, 214.600, and 214.700 are new sections with information pertaining to the Total Joint Replacement episode of care.

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 Arkansas Payment Improvement Initiative Center at 1-866-322-4696 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 301-8311.

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).

www.arkansas.gov/dhs
Serving more than one million Arkansans each year
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

PROPOSED
TOC Required

213.000 CONGESTIVE HEART FAILURE (CHF) EPISODES

213.100 Episode Definition/Scope of Services

A. Episode subtypes: There are no subtypes for this episode type.

B. Episode trigger: Inpatient admission with a primary diagnosis code for heart failure.

C. Episode duration: Episodes begin at inpatient admission for heart failure. Episodes end at the latter of 30 days after the date of discharge for the triggering admission or the date of discharge for any inpatient readmission initiated within 30 days of the initial discharge. Episodes shall not exceed 45 days post-discharge from the triggering admission.

D. Episode services: The episode will include all of the following services rendered within the episode's duration:

1. Inpatient facility and professional fees for the initial hospitalization and for all cause readmissions
2. Emergency or observation care
3. Home health services
4. Skilled nursing facility care due to acute exacerbation of CHF (services not included in episode for patients with SNF care in 30 days prior to episode start)
5. Durable medical equipment

213.200 Principal Accountable Provider

The Principal Accountable Provider (PAP) for an episode is the admitting hospital for the triggering hospitalization.

213.300 Exclusions

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

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

B. Beneficiaries under the age of 18 at the time of admission.

C. Beneficiaries with any cause inpatient stay in the 30 days prior to the triggering admission.

D. Beneficiaries with any of the following comorbidities diagnosed in the period beginning 365 days before the episode start date and concluding on the episode end date: 1) End-Stage Renal Disease; 2) organ transplants; 3) pregnancy; 4) mechanical or left ventricular assist device (LVAD); 5) intra-aortic balloon pump (IABP).

E. Beneficiaries with diagnoses for malignant cancers in the period beginning 365 days before the episode start date and concluding on the episode end date. The following types of cancers will not be criteria for episode exclusion: colon, rectum, skin, female breast, cervix uteri, body of uterus, prostate, testes, bladder, lymph nodes, lymphoid leukemia, monocytic leukemia.

F. Beneficiaries who received a pacemaker or cardiac defibrillator in 6 months prior to the start of the episode or during the episode.

G. Beneficiaries with any of the following statuses upon discharge: 1) transferred to acute care or inpatient psych facility; 2) left against medical advice; 3) expired.

213.400 Adjustments

No adjustments are included in this episode type.
Episodes of Care Section II

213.500 Quality Measures

A. Quality measures "to pass":
1. Percent of patients with LVSD who are prescribed an ACEI or ARB at hospital discharge – must meet minimum threshold of 85%.

B. Quality measures "to track":
1. Frequency of outpatient follow-ups within 7 and 14 days after discharge
2. For qualitative assessments of left ventricular ejection fraction (LVEF), proportion of patients matching: hyperdynamic, normal, mild dysfunction, moderate dysfunction, severe dysfunction
3. Average quantitative ejection fraction value
4. 30-day all cause readmission rate
5. 30-day heart failure readmission rate
6. 30-day outpatient observation care rate – utilization metric

The following quality measures require providers to submit data through the provider portal: qualitative assessment of LVEF, average quantitative ejection fraction value.

213.600 Thresholds for Incentive Payments

A. The acceptable threshold is $6,644
B. The commendable threshold is $4,722
C. The gain sharing limit is $3,263
D. The gain sharing percentage is 50%
E. The risk sharing percentage is 50%

213.700 Minimum Case Volume

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

214.000 TOTAL JOINT REPLACEMENT EPISODES

214.100 Episode Definition/Scope of Services

A. Episode subtypes: There are no subtypes for this episode type
B. Episode trigger: A surgical procedure for total hip replacement or total knee replacement
C. Episode duration: Episodes begin 30 days prior to the date of admission for the inpatient hospitalization for the total joint replacement surgery and end 60 days after the date of discharge.
D. Episode services: The following services are included in the episode:
1. From 30 days prior to the date of admission to the date of the surgery: All evaluation and management, hip- or knee-related radiology, and all labs/imaging/other outpatient services
2. During the triggering procedure: all medical, inpatient and outpatient services
3. From the date of the surgery to 30 days after the date of discharge: All cause readmissions, non-traumatic revisions, complications, all follow-up evaluation & management, all emergency services, all home health and therapy, hip/knee radiology and all labs/imaging/other outpatient procedures
4. From 31 days to 90 days after the date of discharge: Readmissions due to infections and complications as well as hip or knee-related follow-up evaluation and management, home health and therapy and labs/imaging/other outpatient procedures.

214.200 Principal Accountable Provider

For each episode, the Principal Accountable Provider (PAP) is the orthopedic surgeon performing the total joint replacement procedure.

214.300 Exclusions

Episodes meeting one or more of the following criteria will be excluded:
A. Beneficiaries who are under the age of 18 at the time of admission
B. Beneficiaries with the following comorbidities diagnosed in the period beginning 365 days before the episode start date and concluding on the date of admission for the joint replacement surgery: 1) select autoimmune diseases; 2) HIV; 3) End-Stage Renal Disease; 4) liver, kidney, heart, or lung transplants; 5) pregnancy; 6) sickle cell disease; 7) fractures, dislocations, open wounds, and/or trauma
C. Beneficiaries with any of the following statuses upon discharge: 1) left against medical advice; 2) expired during hospital stay
D. Beneficiaries who do not have continuous Medicaid enrollment for the duration of the episode

214.400 Adjustments

For the purposes of determining a PAP's performance, the total reimbursement attributable to the PAP is adjusted for total joint replacement episodes involving a knee replacement to reflect that knee replacements have higher average costs than hip replacements. Over time, Medicaid may add or subtract risk or severity factors in line with new research and/or empirical evidence.

214.500 Quality Measures

A. Quality measures to track:
1. 30-day, all cause readmission rate
2. Frequency of use of prophylaxis against post-op Deep Venous Thrombosis (DVT)/Pulmonary Embolism (PE) (pharmacologic or mechanical compression)
2. Frequency of post-op DVT/PE
3. 30-day wound infection rate

The following quality measures require providers to submit data through the provider portal: use of prophylaxis against post-op Deep Venous Thrombosis (DVT)/Pulmonary Embolism (PE), occurrence of post-op Deep Venous Thrombosis (DVT)/Pulmonary Embolism (PE)

214.600 Thresholds for Incentive Payments

A. The acceptable threshold is $12,469
B. The commendable threshold is $8,098
C. The gain sharing limit is $5,249
D. The gain sharing percentage is 50%
E. The risk sharing percentage is 50%
214.700 Minimum Case Volume

1-1-13

The minimum case volume is 5 total cases per 12-month period.
1. Inpatient Hospital Services (continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

Effective for dates of service on or after October 1, 2012, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Perinatal Care Episodes

Effective for dates of service on or after January 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Congestive Heart Failure (CHF) Episodes
(2) Total Joint Replacement Episodes
2.a. Outpatient Hospital Services (continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

Effective for dates of service on or after October 1, 2012, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Perinatal Care Episodes

Effective for dates of service on or after January 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Congestive Heart Failure (CHF) Episodes
(2) Total Joint Replacement Episodes

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)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

Effective for dates of service on or after October 1, 2012, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Perinatal Care Episodes

Effective for dates of service on or after January 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Congestive Heart Failure (CHF) Episodes
(2) Total Joint Replacement Episodes

PROPOSED
Methods and Standards for Establishing Payment Rates - Other Types of Care

January 1, 2013

3. Laboratory and X-ray Services and Other Tests (Continued)

(3) Chiropractor X-ray Services

Effective for dates of service on or after June 1, 1998, the Arkansas Medicaid maximum for an X-ray will be calculated by using the average of the 1997 Medicare Physician’s Fee schedule (participating fee) rates at 100% for the complete components for procedure codes 72010, 72040, 72050, 72070, 72100 and 72110; or such procedure codes implemented by Medicare, as the AMA (or its successor) shall declare are the replacements for, and successor’s thereto. The average rate will be established as the Medicaid maximum for procedure code Z1928 (Chiropractic X-ray), or such procedure code implemented by Arkansas Medicaid for the purpose of billing a Chiropractic X-ray.

Effective for dates of service on or after July 1 of each year, Arkansas Medicaid will apply an adjustment factor to the Medicaid maximum. To determine the adjustment factor a comparison between the previous and current year’s Medicare rates will be made. The adjustment factor will be equal to the average adjustment made to the Medicare payment rates, for all of the above CPT radiology procedure codes, as reflected in the current Medicare Physician’s Fee Schedule.
A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative ("Payment Improvement Program," or "Program"). The Program:

1. Establishes Principle Accountable Providers ("PAPs") for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.

IV. INCENTIVE ADJUSTMENTS: The Program promotes efficient and economic care utilization by making incentive adjustments based on the aggregate valid and paid claims ("paid claims") across a PAP's episodes of care ending during the twelve (12) month performance period specified for the episode. Unless provided otherwise for a specific episode of care, incentive adjustments are made annually in the form of gain sharing (positive incentive adjustments) or provider risk sharing payments to Medicaid (negative incentive adjustments), and equal 50% of the difference between the average adjusted episode expenditures and the applicable threshold as described below. Incentive adjustments will occur no later than ninety (90) days after the end of the performance period. Because the incentive adjustments are based on aggregated and averaged claims data for a particular performance period, adjustments cannot be apportioned to specific provider claims.

1. Positive Incentive Adjustments: If the PAP's average adjusted episode paid claims are lower than the commendable threshold and the PAP meets the quality requirements established by Medicaid for each episode type, Medicaid will remit an incentive adjustment to the PAP equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation, multiplied by 50% or the gain sharing percentage specified for the episode of care. To avoid incentivizing underutilization, Medicaid may establish a gain sharing limit. PAPs with average adjusted episode expenditures lower than the gain sharing limit will receive an incentive adjustment calculated as though the PAP's average adjusted episode of care paid claims equal the gain sharing limit.
3. Laboratory and X-ray Services and Other Tests (Continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by 50% or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider's net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episodes of care during any performance period shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements during that performance period.

PROPOSED
3. Laboratory and X-ray Services and Other Tests (Continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

Effective for dates of service on or after January 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Total Joint Replacement Episodes

PROPOSED
4.a. Nursing Facility Services (other than services in an institution for mental diseases) for individuals 21 Years of Age or Older – SEE ATTACHMENT 4.19-D

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

(1) Reimbursement for Child Health Services (EPSDT) is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum.

PROPOSED
5. Physicians’ Services (continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

Effective for dates of service on or after October 1, 2012, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Acute Ambulatory Upper Respiratory Infection (URI) Episodes
(2) Perinatal Care Episodes
(3) Attention Deficit Hyperactivity Disorder (ADHD) Episodes

Effective for dates of service on or after January 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Congestive Heart Failure (CHF) Episodes
(2) Total Joint Replacement Episodes
7. Home Health Services (Continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative ("Payment Improvement Program," or "Program"). The Program:

1. Establishes Principle Accountable Providers ("PAPs") for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
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6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

III. MEDICAID PAYMENTS: Subject to the incentive adjustments described below, providers, including PAPs, furnish medically necessary care to eligible beneficiaries and are paid in accordance with the published Medicaid reimbursement methodology in effect on the date of service.

IV. INCENTIVE ADJUSTMENTS: The Program promotes efficient and economic care utilization by making incentive adjustments based on the aggregate valid and paid claims ("paid claims") across a PAP’s episodes of care ending during the twelve (12) month performance period specified for the episode. Unless provided otherwise for a specific episode of care, incentive adjustments are made annually in the form of gain sharing (positive incentive adjustments) or provider risk sharing payments to Medicaid (negative incentive adjustments), and equal 50% of the difference between the average adjusted episode expenditures and the applicable threshold as described below. Incentive adjustments will occur no later than ninety (90) days after the end of the performance period. Because the incentive adjustments are based on aggregated and averaged claims data for a particular performance period, adjustments cannot be apportioned to specific provider claims.

1. Positive Incentive Adjustments: If the PAP’s average adjusted episode paid claims are lower than the commendable threshold and the PAP meets the quality requirements established by Medicaid for each episode type, Medicaid will remit an incentive adjustment to the PAP equal to the difference between the average adjusted episode reimbursement and the commendable threshold, multiplied by the number of episodes included in the calculation, multiplied by 50% or the gain sharing percentage specified for the episode of care. To avoid incentivizing underutilization, Medicaid may establish a gain sharing limit. PAPs with average adjusted episode expenditures lower than the gain sharing limit will receive an incentive adjustment calculated as though the PAP’s average adjusted episode of care paid claims equal the gain sharing limit.
7. Home Health Services (Continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by 50% or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider's net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episodes of care during any performance period shall not exceed ten percent (10%) of the provider's gross Medicaid reimbursements during that performance period.
7. Home Health Services (Continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

Effective for dates of service on or after January 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Total Joint Replacement Episodes
11. Physical Therapy and Related Services (Continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY

I. PURPOSE: In order to assure that Medicaid funds are used to purchase medical assistance efficiently and economically (quality services of the right kind and mix), Medicaid has established a payment improvement initiative ("Payment Improvement Program," or "Program"). The Program:

1. Establishes Principle Accountable Providers ("PAPs") for defined episodes of care;
2. Uses episode-based data to evaluate the quality, efficiency and economy of care delivered in the course of the episode of care, and to apply incentive adjustments;
3. Incentivizes improved care quality, efficiency and economy by rewarding high-quality care and outcomes;
4. Encourages clinical effectiveness;
5. Promotes early intervention and coordination to reduce complications and associated costs; and
6. When provider referrals are necessary, encourages referral to efficient and economic providers who furnish high-quality care.

Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

II. NOTICE and AMENDMENTS: The Program and Program amendments are subject to review and approval by the Centers for Medicare and Medicaid Services (CMS). Rules establishing the Program are adopted in compliance with the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-204. Except in cases of emergency as defined in Ark. Code Ann. § 25-15-204(e)(2)(A), providers will receive at least 30-days written notice of any and all changes to the Episodes of Care Medicaid Manual and State Plan pages.

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IV. INCENTIVE ADJUSTMENTS: The Program promotes efficient and economic care utilization by making incentive adjustments based on the aggregate valid and paid claims ("paid claims") across a PAP’s episodes of care ending during the twelve (12) month performance period specified for the episode. Unless provided otherwise for a specific episode of care, incentive adjustments are made annually in the form of gain sharing (positive incentive adjustments) or provider risk sharing payments to Medicaid (negative incentive adjustments), and equal 50% of the difference between the average adjusted episode expenditures and the applicable threshold as described below. Incentive adjustments will occur no later than ninety (90) days after the end of the performance period. Because the incentive adjustments are based on aggregated and averaged claims data for a particular performance period, adjustments cannot be apportioned to specific provider claims.

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11. Physical Therapy and Related Services (Continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

2. Negative Incentive Adjustments: If the average adjusted episode of care paid claims are higher than the acceptable threshold, the PAP will remit to Medicaid the difference between the acceptable threshold and the average adjusted episode reimbursement, multiplied by the number of episodes included in the calculation, multiplied by 50% or the risk sharing percentage specified for the episode of care. Unless provided otherwise for a specific episode of care, a provider’s net negative incentive adjustment (total positive adjustments minus total negative adjustments) for all episodes of care during any performance period shall not exceed ten percent (10%) of the provider’s gross Medicaid reimbursements during that performance period.
11. Physical Therapy and Related Services (Continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

Effective for dates of service on or after January 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Total Joint Replacement Episodes
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)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

Effective for dates of service on or after October 1, 2012, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Perinatal Care Episodes

Effective for dates of service on or after January 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Congestive Heart Failure (CHF) Episodes
(2) Total Joint Replacement Episodes
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)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

Effective for dates of service on or after October 1, 2012, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Perinatal Care Episodes

Effective for dates of service on or after January 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

(1) Congestive Heart Failure (CHF) Episodes
(2) Total Joint Replacement Episodes
27. Advanced Practice Nurse and Registered Nurse Practitioner licensed as such by the Arkansas State Board of Nursing.
(Continued)

A. INCENTIVES TO IMPROVE CARE QUALITY, EFFICIENCY, AND ECONOMY (CONTINUED)

V. APPLICATION: Complete details including technical information regarding specific quality and reporting metrics, performance thresholds and incentive adjustments are available in the Episodes of Care Medicaid Manual available at https://www.medicaid.state.ar.us/InternetSolution/Provider/docs/docs.aspx and also at the Arkansas Health Care Payment Improvement Initiative website at http://www.paymentinitiative.org/Pages/default.aspx.

Effective for dates of service on or after October 1, 2012, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

1. Acute Ambulatory Upper Respiratory Infection (URI) Episodes
2. Perinatal Care Episodes

Effective for dates of service on or after January 1, 2013, the defined scope of services within the following episode(s) of care are subject to incentive adjustments:

1. Congestive Heart Failure (CHF) Episodes
2. Total Joint Replacement Episodes

PROPOSED